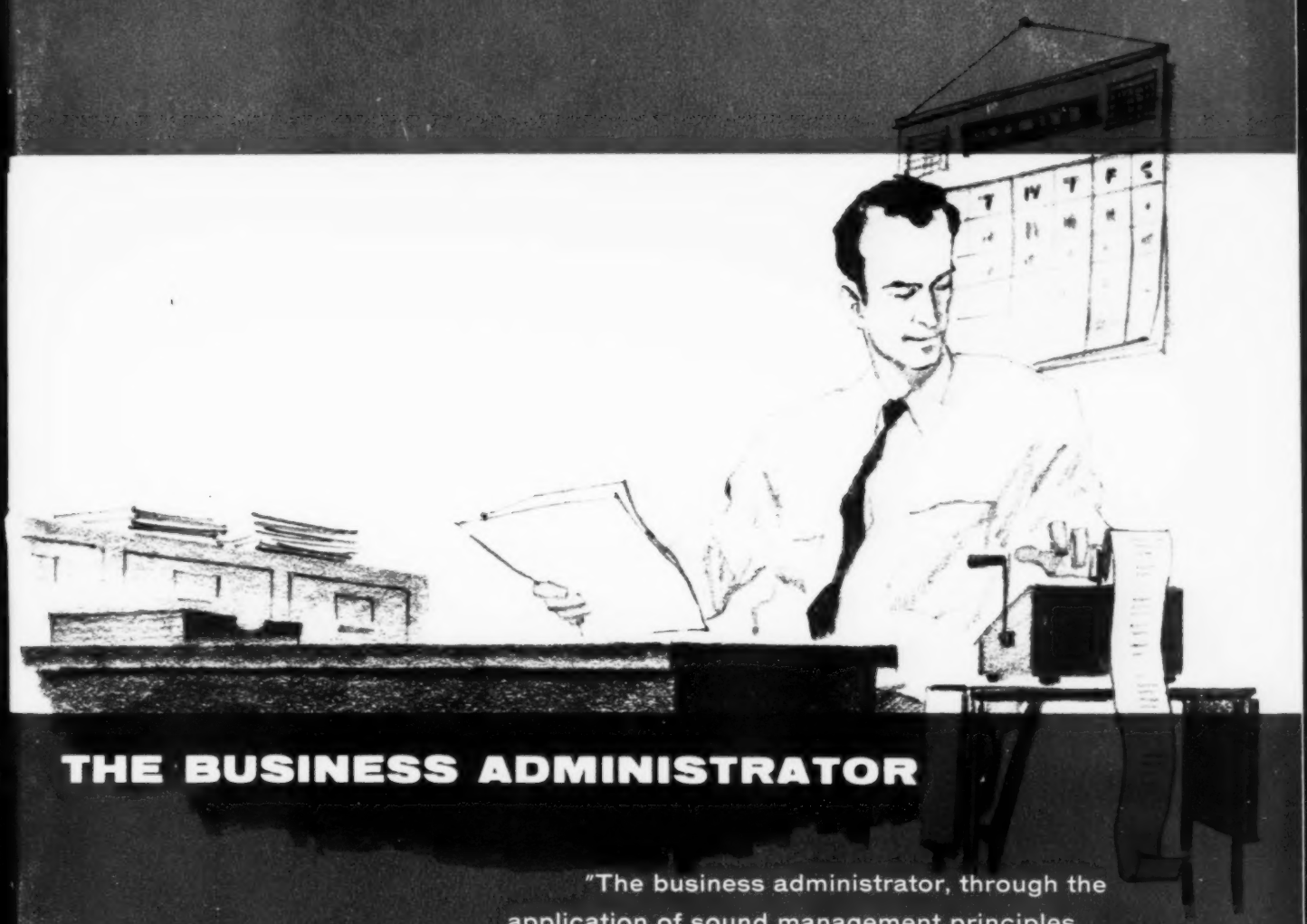
Mental Hospitals

Hospital Journal of the American Psychiatric Association | March 1960



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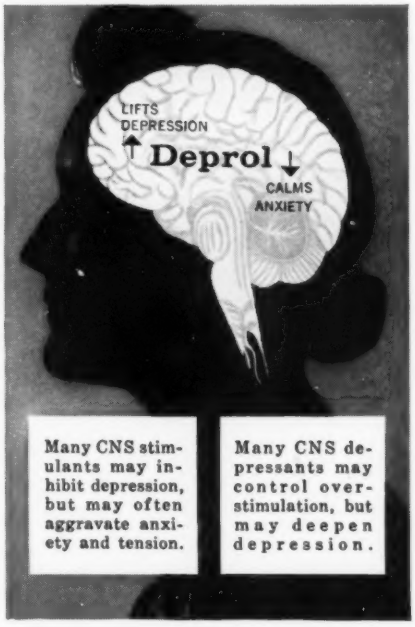

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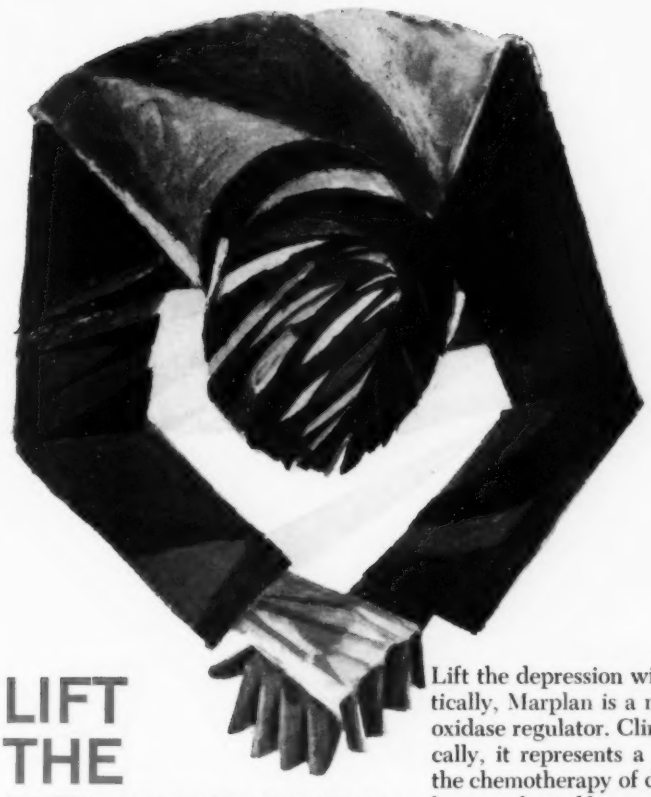

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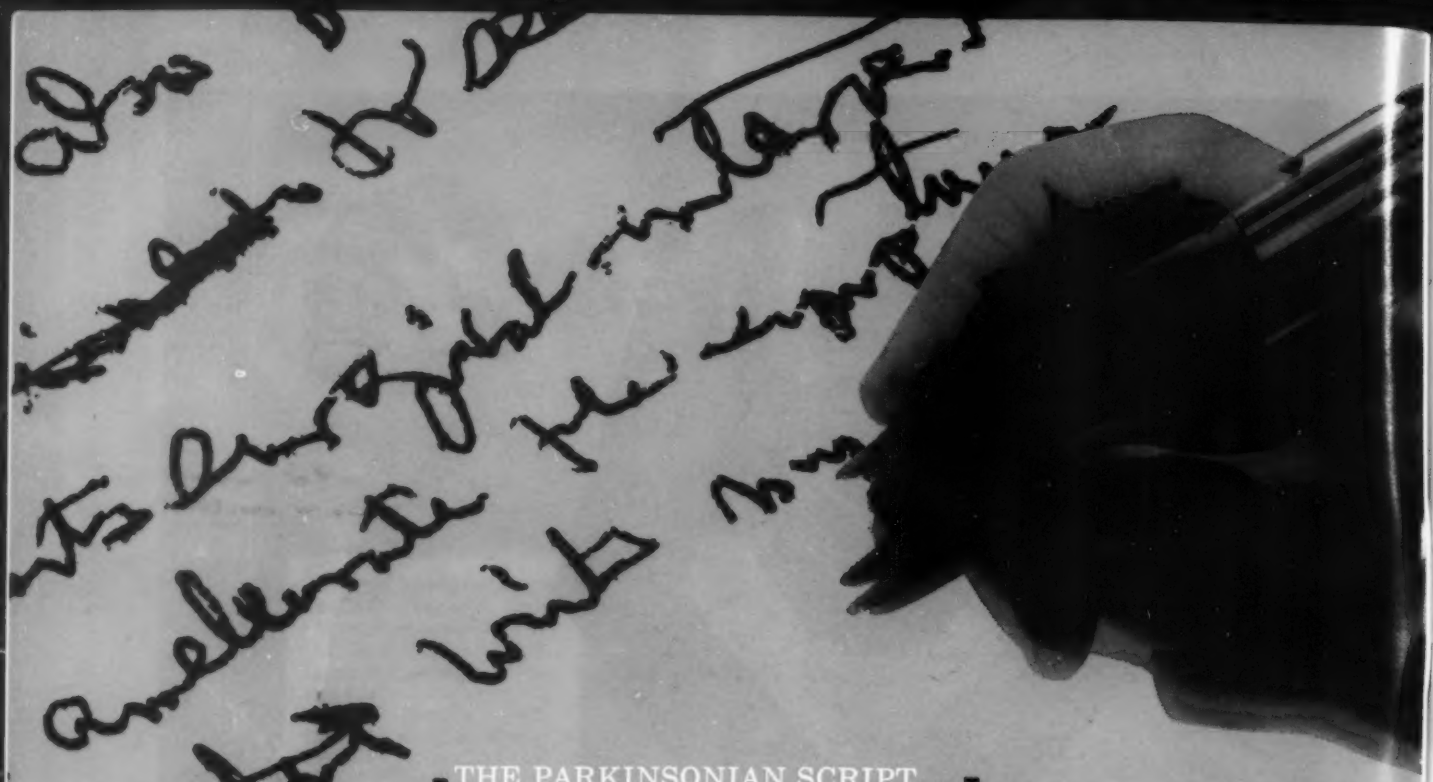

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References: 1. A.M.A. Council on Drugs: New and Nonofficial Drugs 1959, Philadelphia, J. B. Lippincott Company, 1959, p. 252. 2. Doshay, L. J.: J.A.M.A. *162*:1031, 1956. 3. Ayd, F. J.: Clin. Med. *6*:387, 1959. 4. May, R. H.: Am. J. Psychiat. *116*:360, 1959.

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Mental Hospitals

Volume 11 Number 3

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HOSPITAL JOURNAL OF THE AMERICAN PSYCHIATRIC ASSOCIATION

CONTENTS, MARCH 1960

THIS MONTH'S COVER

The quotation on the cover was taken from a personal communication to M.H.S. from Mr. Alexis Tarumianz, business administrator, and Mr. Edward Allport, assistant business manager, Delaware State Hospital, Farnhurst. Mr. Tarumianz is also the president of the American Society of Mental Hospital Business Administrators.

Cover design by Stephen Kraft.

MENTAL HOSPITALS offers a forum for free discussion about matters of interest to persons involved in the care and treatment of psychiatric patients. Opinions expressed by the authors are theirs and do not necessarily represent the official policy of the American Psychiatric Association.

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1. *Ferrand, P. T.: Minnesota Med.* 41:*853 (Dec.) 1958.*
2. *Edisen, C. B., and Samuels, A. S.: A.M.A. Arch. Neurol. & Psychiat.* 80:*481 (Oct.) 1958.*

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A Workable Communications System

By RODGER MENDENHALL
Hospital Administrator
Woodside Receiving Hospital
Youngstown, Ohio

EVERY PERSON involved in the administrative aspects of hospital operation will, sooner or later, face the problem of creating an effective system for communicating essential information throughout the organization. Most often the difficulties in disseminating information are created either by the growing complexity of the organization, or by decentralization; it is obvious to all of us that current trends in psychiatric hospital development are compounding the problems promoted by these two conditions.

Volumes of material have been written concerning communication topics of all types, such as psychogenic considerations involving endless subjects, the grapevine, social interaction, symbols, timing and selling, semantics, and so forth. Such material is the very basis of communicating and as such its importance cannot be described. Strange as it may seem, however, very little has been written concerning the creation and installation of a *system* of communications for "spreading the word" up and down throughout the hospital. The content of this article is neither original nor complete. Nor does it supply the only answer to starting a good system in a hospital. It does, however, include considerations that combine much of the thinking of the authorities, some of the practical points of gathering material and attacking the problem, and a few ideas that may save some time and thought when trying to reach conclusions in analyzing such a system.

Getting Off to a Good Start

The first logical step is to find out what actually exists. In order to be consistent and comprehensive, a questionnaire should be developed for completion by the person in charge of every area of activity. Department heads alone cannot give all the answers; they know that they have passed along the information that came in, but they cannot be certain of its final disposition. It is suggested that a list be made of employees who are to receive a questionnaire, and that this list be discussed with department heads to be sure it is complete before proceeding further.

The development of this questionnaire is probably the most important single step in the whole program. This is the first and last chance to gain an insight into what exists, so the inquiries should be comprehensive but easily understood. The following subjects will be valuable and should be queried:

1. If regulations, bulletins, policies, etc., are currently being issued and kept for reference, which ones are they, and where are they located? (This should be especially clear and specific because much confusion frequently surrounds this subject.)

2. If question 1 pertains, how is it decided which ones to dispose of when "cleaning house"?

3. If question 1 pertains, is there a need for more copies, and if so, where would they be located? Also why is there a need for additional copies?

4. Even though there may be an established method for filing the materials described in question 1, how are such materials actually filed or kept track of for quick reference?

5. How does the recipient acquaint personnel under his supervision with each type of material in question 1?

6. If the person receiving the questionnaire does not have any or all of the materials described in question 1, where or to whom does he go for such information?

7. What suggestions, observations, or criticisms does the recipient have concerning the drafting, issuing, or handling of materials described in question 1?

8. Is a record kept of any other types of communication? If so, what are they?

9. Regardless of where they originated, does the recipient have procedure manuals in any form for the use of his personnel? (Examples might be a diet manual or supply catalog.) If so, please identify them and state their location(s).

10. Does the recipient have a copy(s) of the personnel policies issued by the hospital? Where are they located?

11. Is there some form of job description, such as duty listings or responsibility outline, for personnel under recipient's supervision? If yes, were they drafted by him or by the hospital? If such descriptions exist for only a part of the personnel, which employees are covered?

12. In what location(s) is such information kept?

13. Is any kind of an orientation program conducted for new employees? Please comment.

14. How many bulletin boards are located in recipient's areas of responsibility? If certain bulletin boards are designated for different groups of personnel, please list the groups. Are more bulletin boards needed? If so, where?

15. Does recipient have a written description of purpose, scope, or functions of his area?

16. What is recipient's understanding of the communications route between the lowest position in his areas of responsibility and the administration office? (It is helpful to ask the recipient to draw a non-existent example for the employee to follow.)

17. Is there any type of a reference or procedure manual

with instructions for the completion of forms or reports used in a specific area? If not, how does each new employee become familiar with the completion process?

18. What forms, requisitions, reports, announcements, or other written communications (with special attention to reports of any type) originate from the functional areas under recipient's supervision?

19. Are there any hospital committees in existence that are designed for reviewing considerations in recipient's section of activity or area of responsibility? If yes, which committee(s), and what or whom does each of the members represent?

20. On which hospital committee(s) is recipient's area of responsibility represented?

21. Are there other types of verbal interdepartmental or interpersonnel communications that are necessary for the normal completion of hospital business? If yes, how is it decided when a verbal communication is sufficient, or when it should be in writing?

It is recommended that a carefully worded cover-letter be attached to each questionnaire before distribution. This letter should point out that the purpose is only to eliminate weaknesses in the system, with no desire to criticize any specific areas or their methods of processing communications. Honesty and frankness should be encouraged in order to identify and eliminate any possible confusion surrounding the age, accuracy, value, availability, and handling of specific types of communications of a management nature. Last but not least, each questionnaire should be signed by the individual filling it out.

If possible, the questionnaire should be followed up by a personal interview with the respondent involved. Advantages are twofold: the individual completing the questionnaire has more freedom for additional comments on the subject of communications, and the administrator has a better understanding of the individual's answers.

What To Do with the Collected Data

The administrator's first feeling after collecting all of this material is apt to be one of complete confusion. Actually this is the critical point in the analysis, and very careful handling of the material is essential if success is to be realized. Many approaches are possible, but trial and error have disclosed the following method to be one of the more workable.

The questionnaire returns should be divided into groups which have many peculiarities in common and which will produce more or less equal groupings. The size and complexity of the hospital organization will determine the full extent of this dividing. If a general rule is possible, consideration should be given to separating the questionnaires into three groups: (1) the nursing service (2) all other professional staff, such as physicians and psychologists, and (3) the other services, such as dietary, maintenance, and housekeeping. In most settings this separation of questionnaires will make the stacks comparable in size, and closer inspection will show a common emphasis upon many answers and communication problems within each of the three groups.

A rather mechanical and time-consuming step must take place next; the material must be combined into a logical and easily absorbed form. It will not be necessary to present the weaknesses or shortcomings in each individual area of responsibility; the prime objective is an over-all rehabilitation of the communications system.

In order to put the data into readable form, a decision must first be made as to the relative importance of various items in a communications system. A list of possible considerations follows. This list is by no stretch of the imagination complete, nor applicable in its present form to every hospital. It can, however, serve as a good, basic point of departure for an analysis of any formal system of managerial communication.

Organizational Analysis

A. In each of the questionnaire categories

B. General departmental observations

Written Communications

A. The existence of administrative policies, etc., in each of the questionnaire categories. (Important for consistent action.)

B. The existence of personnel policies in each of the questionnaire categories.

C. The existence of position descriptions and responsibilities in each of the questionnaire categories. (Important to new employees, and to a smooth change-over in case of unexpected sickness or death.) The department head should not be overlooked in this consideration, and a theoretical replacement should be planned for every position on the existing staff.

D. The existence of consistent distribution patterns for communications of limited interest.

E. The types of departmental reports from the various questionnaire categories:

1. Special reports
2. Daily, monthly, quarterly, and annual reports
3. Performance ratings
4. Inquiry reports
5. Educational (interns, nurses) reports

F. A description of the general distribution of information.

Verbal Communications

A. Vertical channels in each of the questionnaire categories. This means ways and means of verbal exchange between the administrative department and the other departments—regular meetings, committee activity, etc.

B. Horizontal communication between departments. Not phone calls and contacts to get the daily work done, but rather the formal, planned contacts designed to integrate the various groups into a common plan of action.

Orientation and Inservice Training

A. In each of the questionnaire categories

B. As an over-all administrative project

Conclusions and Recommendations

The final stages of the study should consist of additional condensation and simplification. One effective means for acquiring this goal is to combine the conclusions and recommendations into five major areas of consideration with certain points of implementation under each.

Sources of Information

A. Institute a central clearing point for the approval, distribution, and review of official communications which apply to more than one department or area of activity, in-

cluding a system for the review and revision of such material.

B. Start a similar system within each department for internal communications.

Means of Transmission

A. Record and follow official distribution lists for various types of communications, and designate responsibility for this distribution as well as the method for accomplishing the proper distribution.

B. Scrutinize meetings of committees, conference groups, departments, etc., with the specific intent of obtaining optimum use of employees' working-time on the job.

C. List areas for the placement of official communications.

D. Be certain that an adequate number of bulletin boards exist. Designate those that are to receive official communications.

E. Consider a house organ.

F. Consider a suggestion system.

G. Consider a grievance procedure.

H. Create a system of department reports to the administration that are meaningful and easy to prepare. Eliminate all reports that are not serving any useful pupose.

Interfering Factors

A. Develop tables of organization so that every employee understands the chain of command.

B. Reduce all official policies and orders to writing, and designate a central clearing point and method for all such releases.

The Receiver

A. Proper orientation and indoctrination are essential. Create department manuals which include information relating to department descriptions, tables of organization, position summaries, personnel policies, etc. In this way employees see how they fit into the department operation, and understand their importance to the organization. Such material clarifies responsibility.

Final disposition

A. Place instructions on each communication for proper filing, a discard date, posting instructions, etc.

B. Furnish manuals to each area on the official distribution list. It is recommended that two manuals should exist in each area of activity, and that each manual should be divided into the minimum number of sections indicated:

1. The Department Manual
   (a) Personnel policies
   (b) Hospital organization chart
   (c) Department purposes and philosophy
   (d) Department organization chart
   (e) Position summaries or work descriptions
   (f) The balance of the manual should consist of departmental rules and regulations entitled "practices," or some other term to distinguish them from over-all hospital policies.
2. The Policy Manual
   (a) A section for hospital policies which apply equally to all areas in the hospital.
   (b) A section for each of the official locations which are designated departments or areas of activity. In each of these sections there should be a one-page description of the department's purpose, in order to aid new employees in acquainting themselves with the hospital functions. The balance of each section should outline the standing orders of procedure for transactions between departments.

Most hospitals have a general policy manual in some form. Preparation and maintenance of this manual should be the responsibility of the administrative office. It is suggested that the department manual should be patterned after the hospital's policy manual, and that the upkeep, except for parts (a) and (b), should be the responsibility of the department head, with arrangements for an annual review by an individual in the administrative section.

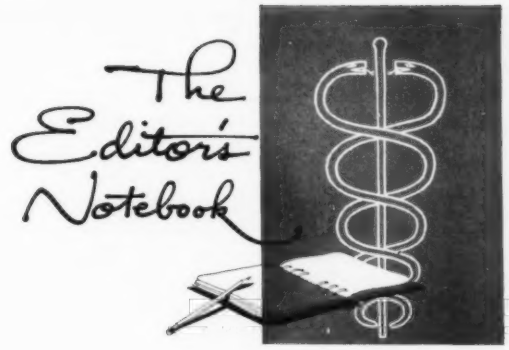
It is important to establish for both manuals a system of numbering which will be consistent and flexible. The terminal-digit method has the advantages of accounting for every page in sequence, continuing indefinitely, and permitting policy numbers and page numbers to be the same.

It is also important to have the same format for the drafting of each document. For example, there might be a standard heading of: the date, the page and policy number, and filing instructions. The first section under the heading would be the "rule"; the second section would contain reasons for the "rule"; and the third section would describe the procedure for carrying out the "rule."

This article has offered a basic outline for attacking communications problems and for the review and analysis of the communications system. Final use of these suggestions must, of course, be adapted for specific organizations. The major value of the material will be the time saved by following the general pattern of logic, arrangement, and approach.

GUEST EDITORIAL

Mr. Albert Deutsch is a nationally prominent journalist, the first of his profession to be made an Honorary Fellow of the A.P.A. (1958). He has conducted many crusading campaigns in both the newspaper and magazine fields, and during the 1940's had a daily health and welfare column (another journalistic first) in the newspapers, PM, The New York Star, and the New York Post. Among his many publications are several books dealing with the care and treatment of the mentally ill in America. His next, for the lay public, concerns research in mental and emotional problems.



Do you remember when "research" was a dirty word, scarcely to be whispered in solemn legislative halls at budget time? Do you remember the basement bootleggers of science, who lurked in dark and dank corners of mental hospitals and fussed with crude, home-made equipment that looked like Rube Goldberg contraptions and evoked a suspicion that moonshine was in the making? Do you remember the unbelieving awe created by the announcement, during the 'thirties, that the Scottish Rites Masons, Northern Jurisdiction, had decided to donate $40,000 a year for research in schizophrenia—a colossal sum for that time?

If you do, then you will have shared this writer's open-mouthed amazement at the current revolution in research attitudes that have reached a point where:

- Congressmen—including some with notorious penny-pinching proclivities—now bawl out Federal executives for *not* asking greater appropriations for psychiatric research.
- A single agency—the National Institute of Mental Health—expends more than $30,000,000 a year (fiscal 1960) for intramural and extramural research.
- Several state mental hygiene departments each include in their annual budget more funds for research than was expended for the entire country twenty years ago.
- Research scientists, who were low men on the totem poles in professional and social status, have been jet-propelled to the top of the popularity polls.

What has wrought these wonders? Many factors can be discerned—some of them unrelated to mental health. For instance, the thrilling discoveries in atomic energy, the enthusiasm for the health-preserving and life-saving potentials of medical science in general, and the lively discussions of psychiatric problems—these and other factors have played a part in promoting support for newer knowledge in the nature and pathology of human emotions.

I've spent two years criss-crossing the country, visiting various centers of psychiatric activity to find out what's going on in mental health research. I've interviewed hundreds of investigators and administrators at these centers, gathering material for a book sponsored by the National Association for Mental Health and financed in part by an N.I.M.H. grant. It has been an absorbing task—more inspiring to me than any other writing enterprise I've undertaken. I saw no signs of an imminent "Great Breakthrough"—although the potential is ever present. What I saw, instead, were modest but meaningful and encouraging advances on many fronts, made by scientists representing many disciplines and reflecting differing and sometimes clashing theoretical approaches.

One of the most striking features of this new scientific push is its impact on American mental hospitals. As one surveys these hospitals today, he finds "the joints are jumping" with research activity. He encounters a Nobel Prize winner leading a research team in one. In another, he finds an imported British scientist of international renown organizing a model research staff and program. Scientific investigators from many fields—biochemistry, biophysics, biostatistics, sociology, anthropology, psychology, physiology, etc.—are being recruited to join with psychiatrists in the war on mental disease.

Undoubtedly, the introduction of the mood-changing drugs a few years ago gave a significant fillip to research activity. Large numbers of mental hospitals that had been previously untouched by research activity joined eagerly in drug-evaluation projects, many of them (such as the Veterans Administration hospitals) on a mass cooperative scale unprecedented in psychiatric history. Dramatic changes in ward atmosphere encouraged many superintendents to plunge further along the research road.

Much of the research, to be sure, is of substandard quality; some of it is downright shoddy. Enthusiasm often outruns realistic limits. There remains, over-all, a desperate shortage of trained clinical and laboratory researchers. Many administrators still give lip-service to research goals while remaining indifferent and even hostile to their active pursuit. They fail to comprehend what has been abundantly demonstrated: that there is no real conflict between research and therapy—that, indeed, the one potentiates the other. The significant fact is that what was long regarded as an institutional luxury—namely, research—is at last widely recognized as a prime necessity.

Albert Deutsch

WAR MEMORIAL BENEFITS PATIENTS

Nationally prominent golfers, including Patty Berg, Betsy Rawls, Joe Kirkwood, and others, have played golf on the "front yard" of the Veterans Administration Hospital in Lyons, New Jersey. The front yard is a ninety-acre golf course which was presented to the hospital by New Jersey's golfers in 1947 as a memorial to all golfers of the state who gave their lives in World War II.

The $40,000, nine-hole layout was designed by Robert Trent Jones, nationally famous golf course architect. Its name, the Coakley-Russo Memorial Golf Course, honors two New Jersey professional golfers killed during the war.

In his acceptance speech at the dedication of the course, H. E. Foster, M.D., then the manager at Lyons, pinpointed the therapeutic value the golf course would have. He said, "Men of all races and creeds will participate in the use of these fairways as they go forth to better health, fuller living, and an enjoyment of the fruits of the victories they have helped to win. Here, stronger bodies will be molded while healthy personalities are being developed, and this new course will make its contribution to our hospital's part in the recovery of our country from the results of war."

In the years since the dedication ceremony, golf professionals in the state have given generously of their time to instruct hospitalized veterans. However, it became evident early in the project that the patients needed more organized supervision to guide the program and inspire continued interest. In May, 1953, the Lyons Unit of American Women's Voluntary Services pledged themselves to assist the recreation staff of the hospital in a permanent annual golf program for the patients.

As a result of these efforts, an estimated 160,000 rounds of golf have been played by patients since the dedication. During a recent season, an average number of 77 played on the course each day. Aside from enjoying the recreation, the patients have terrific pride in the maintenance of the golf course. They work on the greens, and help to keep the course clear of paper, litter, and other debris.

Dr. A. E. Trollinger, the present manager of Lyons, says, "Golfing is an excellent out-of-doors individual and team recreation. It provides therapeutic recreation and is an effective therapeutic modality. Patients are able to release masculine hostilities on a golf ball. Sportsmanship and comradeship are united in healthful surroundings under competitive or non-competitive conditions."

As an indication of its continuing interest in the course, the New Jersey Professional Golf Association recently donated $7,000 for the construction of a golf lounge which will be built on to the recreation building.

A. B. Dillinger, *Assistant Manager*
Donald C. Munson, *Special Assistant*

Transmission Belt

By DR. WHATSISNAME

THE OTHER DAY workmen tore through some wall paper in ward 6 and found a six-foot hole in the wall. It lead to a spiralling duct that dead-ended against the inside of the outer wall of the building. No one knew what it was there for. The senior attendant on the ward—she had been with us 35 years—knew nothing about it. But then Minnie came in to help with the dishes. Minnie had become a patient at the age of 18. She was now 68. Minnie had been there a half century. She knew. It was a fire escape—an old inside-duct chute that patients could slide down. It had been bricked up 40 years ago.

There was poetic justice in this. Minnie had been in the hospital longer than the superintendent, longer than any nurse or attendant. With our 67-year retirement rule, no one was likely to have worked at the hospital more than 40 years, and most of us, of course, much less than that. But we had a fair number of patients who had been with us more than 40 years.

It was a strange thought. The only link to our past was through the long-term patient. Only she knew about the hole in the wall. Only she remembered when we had gas lights; when we installed our first telephone—it was in the matron's office—and even when we bought a microscope. She remembered when $4.75 was the weekly rate, not the per diem.

Probably she is the last of her race. Schizophrenics today don't stay hospitalized so long; mental defectives go elsewhere; manics and depressives get well; seniles come in too late to pile up much seniority. By the next generation we may reach the state where the employees will have had more experience in the hospital than the patients. But as of today, it is still the patient, not the nurse or the doctor, who transmits the heritage of the hospital.

NURSING SERVICE CRITERIA

By CHARLES K. BUSH, M.D.

Chief Inspector, A.P.A. Central Inspection Board

THE NURSING SERVICE is one of the most important parts of the mental hospital, since its personnel have the closest and most sustained contact with the patient. It is little wonder, therefore, that this department is considered an essential one in the Central Inspection Board's rating of hospitals and is one of two departments that must rate at least 60 in order for the hospital to receive conditional approval. Without adequate medical and nursing care, an institution would not deserve the designation "hospital."

The personnel ratios recommended by the A.P.A. Committee on Standards call for one nurse for each five patients in the receiving, intensive treatment, medical and surgical, and tuberculosis services; one for each 20 patients in the geriatric service; and one for each 40 patients in the continued treatment service. Depending on the distribution of patients in the different services, this will usually average out to about one nurse for each 14 to 17 patients. Because of the nation-wide shortage of registered nurses, it is unusual to find a hospital which meets these standards.

Since other nursing personnel—attendants, supervising attendants, psychiatric aides, psychiatric technicians, and practical nurses—are usually in somewhat better supply, many hospitals have more of them than the standards require, in order to compensate to some degree for the shortage of registered nurses. The over-all ratio of all classes of attendants to patients will be about 1 to 5.

It is desirable that there be one person at the head of this service, and the usual title is Director of Nursing Service or Superintendent of Nurses. This person should have adequate training and experience in order to administer what is usually the largest single group of employees in the hospital. Depending on the size of the institution, there should be one or more assistant directors to relieve the director when the latter is off duty, and to assist in the administration of the department.

Since there is usually a fairly large turnover in the attendant classification, it is necessary to have an orientation and training course for new attendants. The individual in charge of training should, preferably, have a degree in nursing education and in most hospitals she has the title of Assistant Director in Charge of Training. Depending on the number of people to be oriented and trained, one or more nursing instructors will also be needed. All new nursing service employees should have at least the orientation lectures before they are assigned to work with patients. The main portion of the training consists usually of lectures, demonstrations, and supervised work, and is spread over a period of from six months to one year. If the hospital has a basic school of nursing or if student nurse affiliates from other hospitals take their psychiatric training at this hospital, a more complete nursing education course will be necessary.

All wards should be supervised by registered nurses on all shifts. When there are not enough registered nurses to have one on each ward, a nursing supervisor may have to cover several wards, especially on the night shift. The receiving, intensive treatment, medical-surgical, and tuberculosis wards should get first priority on the available registered nurses. Those wards which do not have a charge nurse should have the most experienced attendants in charge.

In most places, the nurse is a member of the psychiatric team—the physician, psychologist, and social worker being the other members. Many nurses have been taught to conduct group psychotherapy and are able to organize their wards along these lines. Since nursing personnel supply so many of the needs of the patient, they are in a position to have a marked effect on his recovery. The more knowledge they have, therefore, about mental mechanisms, the better they can understand the patient and help him.

Supplies and Equipment

Nursing personnel cannot do their best job unless they have the necessary supplies and a satisfactory place to work. A table in a hall is not an adequate nursing station. The station should be enclosed so that there is some degree of privacy when a nurse is making entries on the charts, fixing the medications tray, or discussing a patient with the doctor or an affiliate student nurse. There should be a locked cabinet where the medications are kept and there should be utility rooms, clothes closets, and adequate linen rooms.

The director of nurses should hold weekly administrative conferences with her assistants and supervisors. The latter should then hold meetings with their charge nurses and charge attendants to pass on necessary information and receive reports and suggestions.

There should be a procedure book and an administrative manual available on each ward so that personnel can become thoroughly familiar with them. Bedside records should be kept on all physically ill patients and on other patients if this is possible. These records should contain information about the patients' behavior, verbalizations, and interpersonal relations. This information is valuable to the ward physician, and correct reporting is vital if he is to do a proper job. Another record invaluable to all administrative personnel is the 24-hour ward report which summarizes the daily activities.

The basic principles are slightly modified for the hospital-schools for the retarded but only as regards quantity, not quality. The same standards also apply to private mental hospitals and psychiatric units in general hospitals, except that the over-all ratio of nurses to patients should be at least 1 to 5, and where there is a training or research program, this number should be increased several times.

A REHABILITATION CHALLENGE

By JACK BASHAM, Ph.D.
Chief, Vocational Counseling Service
VA Hospital, Chillicothe, Ohio

MENTAL HOSPITALS TODAY are becoming increasingly concerned with the problem of rehabilitation of the chronic, long-term patient. Evidence continues to mount which suggests that, as a group, stabilized, long-term schizophrenic patients can profit from concentrated rehabilitative programs designed to restore them to society as economically independent and socially productive persons. The author conceives of the programs as having three aspects: (1) identification of the resources and potentialities of each patient, which can be developed and utilized to better equip him for the workaday world; (2) within-hospital rehabilitative treatment, with intra-hospital personal, social, and vocational experiences which will help to equip him for extra-hospital adjustment; and (3) extension of the rehabilitative effort into the community, since community involvement is both necessary and desirable. Total rehabilitation does not and cannot take place within the confines of the hospital.

The present "Exit Service Unit" resulted from a research project which took place in 1955, and which was designed to assess the value of personal, social, and vocational retraining toward more successful extra-hospital adjustment for the neuropsychiatric patient. The project involved job experiences and additional responsibilities and privileges for its patient-members. A control group technique was utilized to assess patient-benefit. Results suggested that realistic and meaningful programs geared to individual needs could be beneficial to rehabilitation, and that such programs should be pursued further with continual efforts to develop new and improved assessment and treatment techniques, and to understand better the rehabilitation needs of the patient. Increased learning and experiential opportunities, both within and outside the hospital, which contribute to the feeling of personal worth, to ego-enhancement, to remotivation, and to decision-making abilities appeared to play an important part in the rehabilitation process.

Upon completion of the research project, the program was retained and expanded to include fifty beds of a seventy-nine bed building. This more permanent program was established in February 1956, and the name "Exit Service Unit" was adopted. The decision was made to shift the treatment emphasis from the over-all neuropsychiatric patient to the stabilized, chronic, long-term schizophrenic.

In general, the unit is a part of the hospital's total rehabilitation effort. It is designed primarily to cope with the problems of the patient who does not have other sources of assistance, such as interested family or appropriate community employment opportunities, which could help him in his return to a productive role in the community. Membership in the unit is restricted to those patients who have demonstrated the capacity for handling the responsibilities and privileges inherent in the structure of the unit, or those who appear to possess potentialities for such development.

The treatment philosophy is guided, in part, by the following beliefs: (a) giving responsibility often results in the taking of responsibility, (b) hospital adjustment is not sufficient for community adjustment, (c) prolonged hospitalization is destructive of motivation, decision-making, and initiative for independent action, and (d) realistic success experiences and personal attention foster self-confidence, self-esteem, and a more adequate self-appraisal.

Another important treatment concept is the team approach. It is necessary for all disciplines to work together *with* the patient to achieve the goal of rehabilitation, because of his multi-faceted needs.

Structure and Operational Procedures

Staff Member	*Area of Responsibility*
Director of Professional Services	Consultant to the unit.
Chief, Continued Treatment Service	Over-all responsibility for medical care.
Counseling Psychologist	Supervisor of the unit, responsible for psychological services and over-all unit coordination.
Coordinator, Physical Medicine & Rehabilitative Service	Physical plant administrator and patient paymaster. Supervisor of the Member-Employee Program.
Social Service Worker	Provides pertinent social data, home evaluation, and follow-up information.
Nurses and Nursing Assistants	In addition to regular duties, serve as sensitive observers and reporters of behavioral changes and progress.
Ward Secretary	In addition to regular duties contributes knowledge of patient behavior and guidance on technical and administrative problems.
Recreational Therapist	Provides on- and off-station social activities.
Clothing Clerk	In addition to regular duties, assists patients and offers guidance and training in clothing purchases in community.

Patients are referred to the unit by staff physicians throughout the hospital. A counseling psychologist prepares a Screening Report based on data gathered from personal interview, the patient's clinical folder, ward progress notes, discussion with the patient's staff physician, and psychological testing. A unit staff meeting is held weekly at which the patient's background, current level of adjustment, and rehabilitation potentials are evaluated. He is interviewed and, if accepted, is moved into the unit and becomes a participating member in its activities. He is allowed town passes from 5:30 p.m. to 11:00 p.m. each evening and from 8:00 a.m. to 11:00 p.m. on Saturdays and Sundays. He is encouraged to avail himself of this privilege and to extend himself into the local community. His condition warranting, he is also encouraged to take overnight and weekend passes to surrounding communities in order to broaden his recreation, social, and experiential outlets.

Each patient is assigned to some meaningful and realistic hospital work assignment which is in keeping with his background, aptitudes, interests, and anticipated areas in which he will be seeking employment when he leaves the hospital. His work aptitudes, attitudes, interests, tolerances, and interpersonal skills and needs are determined, not only through psychological testing, but also through data gained from observation on his work assignment.

While in the hospital, the patient is also tested and assisted in the handling of money; he is given cash to spend instead of hospital canteen coupons. A weekly payday is held on the unit at which time the patient is given the opportunity to draw money from his hospital account. He is allowed up to $3 if he plans on remaining at the hospital during the coming week, and up to $7.50 if he plans to visit the local community. If the patient decides to spend the night or the weekend in another community, he is encouraged to estimate his expenditures, to take the initiative in handling his travel and living accommodations while away from the hospital. The same is true if he is granted a leave of absence to visit his home.

Group Therapy

Shortly after his acceptance on the unit, the patient is assigned to an ongoing psychotherapy group under the leadership of the counseling psychologist. The group is structured primarily to stimulate interpersonal relationships, to assist in the handling of everyday reality problems, to motivate, to assess areas of personality conflict, and to assist the patient in the development of self-understanding. Role-taking techniques are used when appropriate.

Although all formal individual counseling and psychotherapy are performed by the counseling psychologist and the social worker on the unit, all other staff personnel are oriented toward dealing with specific individual problems as they arise. To help facilitate this orientation, the nursing-care staff meets weekly to discuss patient needs and to devise techniques which can be used by the staff in working with them. The meeting also provides an additional opportunity for the exchange of patient behavioral data. This staff consists of the nursing supervisor, nurse, nursing assistants, counseling psychologist, and social worker.

The patient is encouraged to take the initiative in matters of personal grooming and hygiene. For example, he has his own razor and razor blades, keeps these in his locker, to which he carries a key, is encouraged to have his hair cut in the local community, and has access to the shower room at all times.

In addition to her other duties on the unit, the social worker meets with the family of the patient. This affords an opportunity to assess their interest in the patient and explore areas of interfamilial strengths and conflict; to lay the groundwork for the patient's eventual return, if desirable, to the family setting; and to help with some of the special problems created by the long period of separation. A very important consideration in planning with the patient about his future is his family and the attitudes of its members toward him. Through the family's understanding of him and his needs, and their willingness to participate in planning with him and with the staff, his chances for remaining outside the hospital are increased.

Family Orientation

In May, 1959, the vocational counseling service prepared a brochure for the purpose of orienting the family to the treatment the unit provides and the activities in which the patient is engaged, both inside and outside the hospital, as a part of his treatment. Following the patient's admission to the unit, the family is notified; a Responsibility Form is furnished for signature and return, and this is accompanied by a copy of the brochure.* The family is encouraged to visit the hospital and patient, to re-establish relationships, and to gain a better understanding of what can be done toward his return. As frequently happens with the long-term patient, family ties may be broken beyond repair or be nonexistent. In these cases, other resources have to be developed.

Although the patient is encouraged to take the initiative in finding his own outlets for social activities during his passes to the local and surrounding communities, the recreational therapist is active in planning in this area. Recreation on the unit has included sporting and theatrical events, formation of a model train club, dancing classes conducted by a professional instructor from the community, bowling and pool tournaments, and talks by local businessmen. In addition, bowling, basketball, and baseball teams have been formed. The Veterans Administration Volunteer Service is active in securing community participation. For example, the local chapter of one of the major fraternal organizations takes a leading role in planning for and participating in social, recreational, and sporting events both within and outside the hospital.

Patient Council

In order to stimulate group identification and to encourage social participation and decision making, a Patient Council was formed. This meets one evening biweekly and its primary function is to evaluate suggestions patients have made for unit improvements. It is composed of a member and an alternate elected by each of the four psychotherapy groups, and is under the leadership of a night nursing assistant. In order to make this opportunity for service available for more patients, each member of the council serves for a set period of time. Related to the council is the Patient

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**Dr. Sam Beanstock, Manager, has kindly supplied six copies of these documents which may be borrowed from the Mental Hospital Service Loan Library.*

Government which consists of the total body of Exit Service patients. The government meets for one hour biweekly, elects its own officers, and conducts its own business. Its primary function is to develop social activities for the unit. Staff members attend if invited.

Job Assignment

Following his transfer to the unit, the patient is seen frequently by the counseling psychologist in order to further assess his motivational level, areas of interest, aptitudes, personality structure, and vocational potentialities. Appropriate psychological tests are used when indicated. A job assignment, commensurate with interview, testing, and observational findings, is made. This might involve placement in one of the physical medicine and rehabilitation activities, such as manual arts, educational or industrial therapy; in the housekeeping division; the dietetics service; or in various administrative offices throughout the hospital. Following the patient's assignment, close contact is maintained with his supervisor to determine his work adjustment, his work attitude, and problem areas.

To stimulate interest in the vocational area and to broaden the patient's scope of vocational knowledge, trips to industrial plants in the surrounding area are arranged. These serve a dual purpose. Not only do they benefit the patient, but they also serve to educate employers as to the purpose and functions of the unit. To further stimulate employer participation, the vocational counseling service organizes and conducts Hospital Industrial Seminars which serve to bring employers and employment service personnel of this and neighboring states to the hospital.

When the patient's improvement warrants it and when jobs in the local community can be developed, he might be placed on night-resident status. As a night resident, the patient is employed in the community during the day and returns to the unit at night for continued treatment and supervision. This provides another technique for evaluating his progress and flexibility for change. The counseling psychologist makes frequent contact with the night resident's employer to determine his over-all functioning. Night-resident status can be a very important step for the patient in leading toward eventual release from the hospital and full-time community employment.

Member Employee Program

Another avenue of employment is the patient's participation in the Member Employee Program.* This program is also a part of the Exit Service Unit. The patient is selected for membership after a period of observation by the unit staff in order to determine his capacity to adjust to the additional responsibilities. When the patient is transferred to this program, he is placed on trial-visit status and employed by the hospital under Civil Service. He is employed regularly, eight hours a day, five days a week, and is paid for his work. He is granted a certain amount of annual and sick leave, is furnished with board and a semiprivate room in personnel quarters, and is entitled to medical treatment when indicated. He is free to leave the hospital at any time during his non-working hours. As with the night resident program, this program is geared to provide the patient with success experiences, with opportunities for increased feelings of confidence in his abilities, and with job training and experience which can be used to good advantage upon his return to the community.

When the patient has reached the level at which discharge planning can be consummated, the counseling psychologist assists him in finding suitable employment in an appropriate environment. This is done either through personal contacts with employers or through cooperative effort in the selective vocational placement of the patient.

When it is indicated, the patient might be placed in training either under the various Public Laws, in which case the hospital and the Vocational Rehabilitation and Education Division of the VA Regional Offices coordinate their efforts, or through the Office of Vocational Rehabilitation or the State Bureau of Vocational Rehabilitation. Following placement either in employment or training, close follow-up with both employer and worker is maintained to determine the over-all adjustment and to assist the patient in the readjustment process.

Implications for Further Growth and Development

The Exit Service Unit has been in operation since February, 1956. It is currently in the process of expanding to its building capacity of seventy-nine beds. Since its inception, other Veterans Administration and state hospitals have adopted units similar to the one reported above. The unit represents the outgrowth of the team concept in patient treatment which brings together the efforts of many hospital personnel in the achievement of a common goal . . . rehabilitation of the mental patient.

Although one is reluctant to reduce a very complex and complicated process involving human behavior to a circumscribed and depersonalized statistic, it is through such statistical evaluation that results can in part be determined and improved techniques established.

The patients with whom the unit staff has worked have had an average of seven years of continuous hospitalization, with poor prognoses. The results, as measured in terms of patient discharge, have been approximately eighteen a year with a return rate of somewhere between 18 and 20 per cent. This compares favorably with the national average of approximately 37 per cent return rate from trial visit.

Not only have we found that many chronic schizophrenic patients can be rehabilitated and can resume a productive role in society at a level comparable to their premorbid functioning, but also it has been determined that some can perform at a level higher than that demonstrated at any time prior to their hospitalization.

Despite apparent progress, a continuing and expanding effort needs to be made in the three areas formulated in the first part of this paper; better and more sharply defined techniques of assessment and evaluation of rehabilitation potentials need to be developed. Within-hospital rehabilitative treatment can be improved with the advance of psychiatric and psychological knowledge and with further emphasis on the personal worth, dignity, and self-esteem of the schizophrenic patient. A continuing effort must be made to develop and insure continued community support in providing both social and vocational opportunities for our patients if we are to complete the process of rehabilitation.

**See* MENTAL HOSPITALS, *Sept. 1953, p. 7, and Mar. 1956, p. 15.*

Team Work on an Exit Ward for the Chronically Ill

By BEDE F. HOWARD, M.D.
Chief, Continued Treatment Service
VA Hospital, Coatesville, Pennsylvania

MANY ARTICLES and texts have recently focused on the team approach, subscribing to the concept of "interrelatedness, harmonious interaction, integration, and coordination." The author through his experiences now knows more of the real meaning of these terms, which, though musically intonated and smoothly vocalized, are accomplished only with hard work, honest interdisciplinary criticisms, and the removal of innumerable obstacles based on interpersonal difficulties of variously disciplined psychiatric personnel with diverse personalities and variegated opinions, ideas, and convictions. Their multicolored concepts regarding the adaptability and flexibility of patients for social and/or vocational rehabilitation, particularly on an exit ward comprised largely of chronic schizophrenics, must be wrought into a unified, meaningful, and mutually acceptable program of operation. The team approach requires not only their presence as qualified personnel, but their integration as members of a harmoniously interrelated group whose combined efforts alone can accomplish the predetermined goals of social and vocational rehabilitation.

This paper attempts to focus upon the problems initially encountered in the establishment of an integrated team effort on an exit ward of the Coatesville Veterans Administration Hospital. Although the departments and the individuals representing them varied significantly in their respective roles and relative importance and value, the need for performing with wholesome relatedness was demonstrated quite early.

Pre-Integrative Phase of Ward Organization

The exit ward of this hospital when established in 1956 consisted of 142 chronically ill patients who, with rare exception, were classified as suffering a schizophrenic illness. Prior to the opening of the ward and its gaining the official label of "exit ward," most of the personnel mentioned in this report served their respective roles with individual virtuosity, yet in an unintegrated, loosely organized, and some times mutually antagonistic atmosphere. This was partly and understandably attributable to a multiplicity of factors over which no individual member had any control. For example, the unavoidable shifting of medical personnel in accordance with staff needs, promotions, entry into residency training, resignation, etc., contributed to lack of stabilization, wholesome coordination, and interrelatedness. Administrative and clinical policies, introduced by the physicians in transit, were necessarily ephemeral. During part of this period also, part-time ward physicians, encumbered by responsibilities in another service, unwittingly relinquished their roles to ancillary personnel. Each discipline—nursing, social service, psychology, and physical medicine and rehabilitation—due to part-time supervision, operated in isolation, entrenched in its respective role, maintaining respectable and qualified professional attitudes, but effecting little, if any, harmonious integration.

Commenting on this early phase of ward organization, a team member stated: "Our main problem was that each department was striving for recognition. This resulted in poor communication between personnel and patients, regardless of the fact that we were all working toward a common goal—the rehabilitation of the patient. Unknowingly we were working against each other. I felt that we were misinterpreting and misunderstanding each other's role on the team. As a result, the team members displayed hostility and resentment toward one another. Their unhappiness was reflected in the patients, who appeared frightened and insecure."

The early problems as seen from another team member's viewpoint were poignantly focused on a "service" and then elaborated additionally to include all team members: "I am amazed, horrified, and unbelieving of what actually happened. I use these terms because at that time the professional disciplines on the ward found it extremely difficult to work with each other . . . There were numerous and difficult conflicts. My conflicts were mainly with one particular service. It seemed as if this service failed to recognize that it worked with one aspect of the patient's problem. Our differences among ourselves were so full of intense feeling about one another, that the director of professional services had to schedule meetings with the team." Continuing with her feelings prior to the establishment of a stabilized situation: "There were at least three changes of doctors which made the efforts of the team subject to change depending on the doctor."

A third team member spoke of "confusion of aims among the various services and the problem of different team members working with different patients. Also there were technical difficulties: variability in scheduling of meetings and staffs, the fact that not all services were represented at staff, and the problems of over-lapping of work-effort by the various services."

The psychiatric aide, our "informal psychiatrist" and certainly honored in numerous articles as an integral part of the entire hospital therapeutic program, expressed himself uninhibitedly with unquestioned honesty and remarkable insight when he said: ". . . aides are provided with many opportunities to observe the patients in a way not encountered

by the professional staff member. Staff progress was many times impeded due to the fact that the staff members failed to communicate among themselves, and as a result, our staff meetings were prolonged and indecisive. . . . The aide often did not feel himself as part of the ward team . . . because some professional staff members feel it beneath their dignity to consult the aide. This is quite evident in the manner of approach that various aides experience when encountered by professional staff members."

A fourth team member, a liaison staff person between the various services, stated: "It was hard to believe that the actions of the team would cause the patient and employees to erupt with mingled emotions." This opinion and those of the other staff members clearly reflect the deleterious and subtly exacerbating influences on patient illness and employee morale, often expressed in the psychiatric literature.

It is noteworthy, even extraordinary, that despite the aforementioned interactional and interdisciplinary problems, coupled with the lack of sustained leadership, the group effected a respectable therapeutic program including the release of fifty-five chronically ill patients on trial visit. Additionally, despite the prevailing handicaps and obstacles to harmonious integration, the routine ward functions and operations of the individual members in relationship to their respective roles continued with respectable momentum. What could happen and did happen with improved ward organization, stabilization of personnel under sustained leadership and guidance, and the problems both old and new, is the basis of what follows.

Initial Administrative Changes and Their Effects

Beginning in mid-summer of 1957, with management approval, the author assumed the role of ward administrator. All of the problems did not graciously vaporize for the new administrator! Indeed there seemed to be an intensification of interpersonal conflicts, further retrenchment and fortifying of previously established positions. The introduction of "dynamically oriented" ward concepts evoked mixed feelings. The ward personnel, inadequately indoctrinated, and unattuned, showed skepticism, discontent, and turmoil which resulted in their seeking refuge in their respective chiefs of services. The ward administrator contributed more than his share to the transient turmoil by introducing changes, at first with minimal participation by his co-workers. The pace of reorganization was rapid and understandably created confusion. During the early phase of the newly inaugurated system, many routinized ward procedures, habitually indulged and perpetuated for whatever cause, were altered in accordance with the administrator's psychiatric concepts. Thus early momentum was characterized by revamped pass, privilege, and leave policies, based not on overpermissiveness but on their being merited by the patient's condition. Screening and evaluation of patients resulted in many transfers to more closely supervised areas. Many stabilized schizophrenics and habitués were referred to the vocational counseling and social service departments for trial visit planning. Other patients had their assignments changed, more in keeping with their potentialities, assets, and limitations. More frequent staffings were scheduled, group therapy was expanded, the nursing service was asked to expand its observations and operations, and the aides were expected to write more frequent and more descriptive notes on patient charts. These and other measures intending to evoke greater, more meaningful participation were aimed at exploiting to good advantage the true potential of the available staff members who were unquestionably possessed of superb qualifications and talents.

It was several months, however, before an integrated program with full team cooperation gradually but painfully evolved through team conferences, staff meetings, and informal daily contact. The ward administrator mingled freely and informally with the staff members. All were seen and engaged in friendly chats either in their offices, in the corridors, in the administrator's office, or elsewhere. The weekly conferences scheduled every Tuesday were informal, without time limitations, and conducted in a friendly warm atmosphere. Any and all questions were encouraged and thrown open for discussion, to achieve concurrence rather than lingering doubts. Several sessions were focused on the administrator's psychiatric training, experiences, and ideas regarding institutional patients and their problems. At other times, general discussions relating to psychiatric problems of whatever nature were conducted in seminar style.

Team Reactions to Changes

No miracles were wrought, and personality differences continued, but in abated form, as there gradually emerged a common understanding and a mutual acceptance of aims and goals. Randomness, blanketing, circumvention, and open hostilities ceased. What appeared to be an overwhelming schedule was soon considered challenging, stimulating, and morale-raising. Results obtained with our patients graphically portrayed our gradual transit from disorganization to smooth and harmonious coordination. Another noteworthy satisfaction was the ability of the unit staff to relate to new "team members," whose services were deemed necessary to accommodate the accelerated program. One newcomer, a well-trained and experienced worker, stated: "The team was already functioning on the exit ward when I was assigned. . . . To be part of the team was something I looked forward to with pleasure. However, in the beginning I found that there was much more involved in this method of planning for the patient than I had anticipated. Although the members of the team seemed sincerely pleased to have me join them, it was some time before I really began to feel like part of the group. Part of this undoubtedly related to my own feelings of uncertainty about 'measuring up' to what already had been established." Her expression of the following certainly reflects on the crucial area for all: ". . . it became apparent I would have to adjust to the various personalities of the team members and their methods of working with the patient. As an acceptance of each member's contribution toward the patients' welfare developed, the feeling of antagonism subsided. This was replaced by an appreciation of the help that can be given to the patient through the combined efforts of a number of people."

Her co-worker, who had earlier expressed herself unreservedly as being "amazed, horrified and unbelieving," subsequently felt: ". . . as you work with people of other disciplines, you begin to know and understand them and have trust in what they, as professional members, can contribute to the goal of helping the patient to regain his health. . . . The true meaning of the word 'team' seemed to become real to me as, one by one, our working together became a trust-

ing relationship." A very significant and real accomplishment is represented in the following: "The patients seemed to have felt the oneness we represented, and it became difficult for a patient to play one team member against the other, which had been the case in the beginning."

The first quoted team member now reflected: "We shared common attitudes and we began to act and think as a group. At first the focus was on the staff rather than on the patient. Soon a marked change was noticed in the morale of the personnel which then reflected itself in the behavior of the patients. It is difficult to describe the feeling one has, seeing chronically ill patients finally rehabilitated, making plans for the future, and thanking us all for our efforts in their behalf. . . . None of this could be accomplished without the team approach."

High Standards Maintained

The third team member, an exceptionally well-qualified, most conscientious, and dedicated worker, now expressed herself thus: "One of the outstanding things about the Building Four team . . . was the maintenance of the highest possible standards for professional work by every service participating. Although relatively large numbers of patients were staffed by a comparatively small group, at no time did expedience or hasty judgment influence the treatment and planning for the patient."

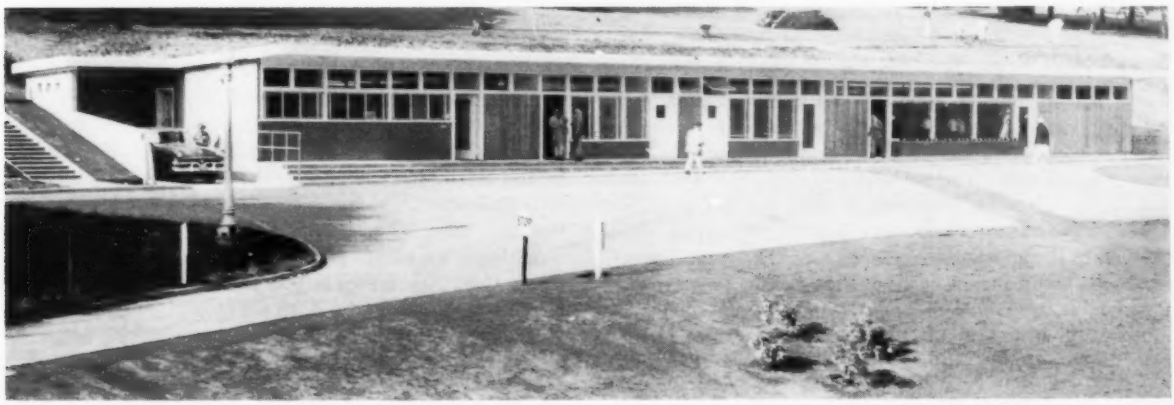
The fourth team member, commenting on the early and subsequent attitudes of the patients and personnel in the shop areas, quoted them respectively as saying: "Are they going to put me out?" "Why must he be reassigned?" "He is part of our team; this is not your department, so stay out of it." These apprehensions of patients and disruptions of team relationship between patients and personnel in the shop areas eventually changed. "As the ward team began staffing four to five patients per week and trial visits began to multiply, patients previously poorly motivated inquired about possible staffing and trial visit. Gradually the personnel became more receptive toward the team concept, and the hospital began to focus on therapeutic change and ultimate rehabilitation."

Our team aide, who had uninhibitedly expressed early resentment, experienced satisfaction as "organization improved and we gained confidence in each other, and as the staffings became more orderly." He began to reflect on his role as that of "liaison between the patient and the professional members, to bring to each any message or information that may further the professional worker's evaluation of the patient." He spoke of his truly intimate role with the patient, wanting to help him in every possible way and "casually insisting that I be addressed by my first name, and after a short period of time, addressing him likewise."

Summarizing, the author wishes to state without qualification that his interaction with professional ancillary personnel in this setting gave him a wholesome respect and appreciation of their invaluable contributions to patient welfare. The experience greatly enhanced his professional maturity, as it provided an unexcelled opportunity to learn more of the various disciplines, their modes of operation and their intimate problems. Truly, as the aphorism states: "There is no substitute for experience." Our interdependence engendered latent talents, and we became imbued with the need for harmonious interaction and unity of purpose. We have achieved growth for our professional selves and improvement for our patients. At the end of one year our results showed over 146 per cent increase in the hospital's trial visit rate for chronic schizophrenics.

This article should not be concluded without mentioning the award granted by the management for "Group Sustained Superior Performance" which included not only the aforementioned staff members, but also the secretaries and clerk whose invaluable services contributed much to effect smoothness and efficiency of operation. Their interrelated roles, all too seldom mentioned, should never be underestimated in ward functioning.

THE VILLAGE SQUARE



The building above is located on the grounds of the Provincial Mental Hospital at Essondale, B.C. It houses a post office, the Employees Credit Union office, public washrooms, the office and lounge of the volunteer headquarters, and a small sundry store, the Tucke Shoppe, operated by the Canadian National Institute for the Blind.

This store carries a large assortment of cigarettes, candy, fruit, magazines, etc. for purchase on the premises or delivery to patients unable to leave the wards. It also includes a coffee bar. All facilities of the one-story building are open to patients and staff as well as to visitors and relatives.

Automation in Patients' Trust Fund Accounting

By H. C. PIEPENBRINK
Business Administrator
Manteno State Hospital
Illinois

IN MOST LARGE MENTAL HOSPITALS the handling of patients' funds presents a problem both in the control and safekeeping of these funds and in the matter of their expenditure. Patients spend most of this money in hospital canteens or commissaries for incidental toilet articles, cigarettes, snacks, etc. In addition, their funds are spent for clothing and other miscellaneous items, and, in some states, for maintenance and care. The main problem is to devise adequate means for receiving these funds from relatives or friends and disbursing them efficiently to the patients in frequent and small amounts for commissary purposes. For many patients too ill to handle cash themselves, additional means must be used to safeguard their money. Coupon books, punch cards, and various other means have been used for this purpose at different hospitals.

In most of the above procedures all or part of the clerical work and accounting is usually done manually. Such was the case also at Manteno State Hospital before we converted to accounting machines. Upon receipt of funds for patients, a handwritten, autographic register receipt was made out in quadruplicate. Periodically during the week, these receipts were posted to the patients' ledger cards. This procedure made necessary much checking of cash against adding machine tapes against ledger cards to find and correct errors. Checking and segregating receipts of various types, such as Social Security checks, Veterans Administration checks, personal checks, and cash for bank deposits, reports, etc., was also necessary.

Punch Cards Prove Inadequate

Money was disbursed from the patients' accounts by commissary card, check, and cash, which were entered manually in a cash-disbursement book and later posted to the patients' ledger cards. The commissary cards had accounts printed on the edges for punching at the commissary when sales were made. These cards were individually typed and then posted to the appropriate ledger cards. The commissary received sales credit for the cards as soon as they were typed. This, of course, presented problems in making an adequate accounting and inventory of commissary sales, since many patients were not fully utilizing the commissary facilities, even though money was available to them. For these and other reasons, we discarded the punch-card system in our consideration of new methods.

Under the new accounting procedure a Burroughs #F1300 Typing Sensimatic Accounting Machine is used for recording trust fund transactions. This machine is capable of storing eleven different totals, which enables the system to go from one operation to another at will and retain totals in each category.

With this equipment a pre-numbered receipt with multiple copies is used. The receipt is inserted in the accounting machine along with the patient's ledger card, and the operator posts both in the same operation. In addition to promoting speed and neatness, the machine reduces the possibility of posting errors, inasmuch as the information is entered on both the receipt and ledger card as the transaction occurs, not some hours or days later.

Disbursements are made by checks written simultaneously with the posting to the patient's ledger card. These checks are printed with snap-out-type carbon duplicates for the hospital, thus eliminating the use of check stubs and facilitating bank reconciliations. Cash disbursements are made in the same manner as checks, except that a cash-disbursement form is used. The patient or an authorized person signs the disbursement form as a receipt for the cash.

Commissary cards are now written in a manner similar to checks, with the ledger posting being done in the same operation. The commissary cards are distributed by trust-fund personnel to ward locations, where they are filed alphabetically by ward personnel. In the case of open wards, the cards are given directly to the patients for their personal use at the commissary.

The accounting machine is capable of giving running totals by classification of various types of disbursements as well as receipts, which makes it possible to change from one type of transaction to another at any time. All of these transactions appear on the journal sheets for auditing purposes. The machine is cleared daily and totals posted to a control card. This one machine handled all of the trust fund transactions for approximately 4,000 individual accounts in the course of a normal eight-hour working day, seven days per week.

New System for Commissary

A companion machine, a Burroughs Director, which is of smaller scope than the above machine, was purchased for the commissary. The new procedure is as follows: ward personnel make up orders for individual patients, attach the appropriate cards to the orders, and forward them in a locked container to the commissary. When the commissary fills the order, the patient's card is inserted into the machine, which picks up the old balance, records the sale, and automatically computes the new balance. The amount of the sale is also automatically recorded on a tape in the machine. In this way the machine accumulates the total daily sales, which can be added to the cash register tape for cash sales, to accurately establish all sales made. The commissary cards are good for one year only, at the end of which time they are cancelled and any balances are transferred to new cards of a different color.

With the introduction of the new equipment, better service has been provided to patients. They receive commissary cards faster and obtain quicker service at the commissary. The patients' accounts are posted accurately and promptly, and better control is maintained over the funds. The commissary sales are correctly stated, which gives better control in this area. Personnel in the clerical area are being more efficiently used, and enough money has been saved to more than pay for the equipment.

VOLUNTEERING FOR

STEP-BY-STEP REHABILITATION

BY BERNARD PAVORSKY, M.D.
Supervising Psychiatrist
Middletown State Hospital
New York

AS A PART of an ongoing and progressive rehabilitation program at the Middletown State Hospital, some of the patients are serving as volunteers to assist other patients in their own institution. These "Blue Ladies," a term adapted from the more familiar Red Cross Gray Ladies, perform many and varied duties for those less able than themselves to function in the daily life of the hospital. An important and intentional byproduct, of course, is the therapeutic benefit which accrues to the Blue Ladies themselves from their service.

The greatest difficulties which most of our patients experience in living are due to the following factors: lack of self-respect, self-confidence, and self-reliance; lack of motivation and interest in life; incapability of sustained effort in a job or any planned activity; inability to get along with people or to enjoy the common rewards of daily life. From a dynamic point of view many of their symptoms are defenses against these incapacitating disabilities. Whatever their cause, diminishing or removing these shortcomings can be of great therapeutic value.

In the Talcott Hall Intensive Treatment Service of Middletown State Hospital, the program is geared in this direction. This service comprises about 280 chronically ill patients, mostly schizophrenics, with hospitalization of many (5-20) years duration. Group psychotherapy, group activities, intensive drug therapy, and electric shock treatment, if necessary, are applied in a therapeutic milieu to enhance patients' healthy reserves and their ego-strength. Our aims are reawakening, remotivation, resocialization, and rehabilitation of our patients through a long-range plan, with the ultimate hope of preparing them step-by-step for release, or at least for a happier existence in the hospital community.

As an initial move in this long-range plan, the institution of Blue Ladies was introduced by the writer of this article in September, 1958, with the idea of arousing the patients' interest in other patients and in helping each other on the road to mental health. An organizational meeting was held and it was explained to the patients during a "self-government" meeting that we were going to create a movement similar to that of the Gray Ladies, with the difference that in this case the volunteers taking care of patients would come from the patients themselves.

The following rationale and principles were laid down:

(a) A Blue Lady is a patient who is taking care of another patient or patients.

(b) The work of a Blue Lady is absolutely voluntary. She may choose her patients and select the time, frequency, and place of her work.

(c) In order to make her service beneficial for herself and her chosen patients, the Blue Lady should set up and adhere to a definite work-schedule.

(d) Each Blue Lady should keep track of the work she has done and report on it, in writing if possible, at regular meetings.

(e) A meeting of Blue Ladies will be held at least once a month. The minutes of these meetings will be published in the patients' monthly newsletter, *We Speak*.

(f) Each Blue Lady will get a special card giving her free access to other wards of the service and entitling her to take out any other patient.

The idea of patients helping other patients or working in the industries or shops in the hospital is, of course, as old as state hospitals. What is new in the Blue Ladies institution is an attempt to organize the patients' activities and make them more meaningful. The program requires constant work, patience, and encouragement on the part of doctors, nurses, and attendants. The activities of the Blue Ladies need to be not so much supervised as cultivated, and new members need to be enlisted whenever possible.

During the first year of the program, fifteen meetings were held with good participation by the Blue Ladies, their attendants, and the nurses. The total number of Blue Ladies reached 50, with as many as 40 of them active simultaneously, some putting in many regular hours of work each day, others working only from time to time. The degree of activity varied a great deal, depending, of course, upon the state of mental health and the ego resources of the particular patient.

Participants Are Unselected

We make no selection of the patients who are willing to become Blue Ladies. Some of them hallucinate actively, some just emerge from complete inactivity or even muteness of years' duration. That is to say that although some of the patients at the time when they become Blue Ladies are in a state of improvement, very many are still quite sick at that time and their participation as a Blue Lady has unquestioned therapeutic value for them.

The services which these patient-volunteers perform are manifold and diversified. One patient does many hours

of secretarial work, typing *We Speak*, stenciling it, typing circular letters, reports on sessions of psychotherapy, etc. She has also typed a complete drug manual for the hospital. This is a patient, hospitalized almost nine years, who not long ago was kept on a closed ward and showed no initiative or ability to work. She now goes on home visits, is on an open ward, and in spite of a great residue of her mental illness, we are making plans for her release. She is fully aware of what being a Blue Lady did for her by giving her back the feeling that she can be useful and the hope that she might hold a job after she has worked so efficiently in the hospital.

Another Blue Lady serves as a receptionist and typist in one of our buildings; still another works in the Special Agent's office. Blue Ladies escort patients to the clinics in the hospital, or go to the infirmary and take out patients in wheel chairs. Some work in the geriatric building, helping to care for our seniors, reading to them, playing games, etc. These have been patiently trained for their work by nurses and occupational or recreational therapy workers.

Some of the Blue Ladies take care of a whole group of patients, reading books to them, playing games with them in the evenings, and so forth. One lady organized a music appreciation group in which patients gather and listen to recorded, serious, classical music. Many of the Blue Ladies limit their activities to taking other patients out for walks to the community store or writing letters for them. They are allowed to take other patients to the city of Middletown for shopping or movie-going and one of them regularly takes a patient on a bus to visit the patient's father, who is infirm and cannot come to visit his daughter.

Activities Suited to Individual Capacities

The above description is detailed enough to give an idea how diversified can be the activities of a Blue Lady to suit her capabilities and to give her a satisfaction of accomplishment and a feeling of self-respect and security, derived from a purposeful achievement and from an ability to carry on an organized day-in-day-out activity as a preparation for organized life outside the hospital.

The responses of the patients themselves and of the nurses are very satisfactory. The following are verbatim quotations from the Blue Ladies and nurses' reports as they were published in *We Speak:*

E.K.: "I hope the patient I have been taking out has enjoyed it just half as much as I have enjoyed doing it, though I haven't accomplished much as yet. My little lady talks to me a little more than she did in the beginning, she knows me and understands me and this is encouraging. I hope to have a better report in the near future, at least I am going to keep trying."

L.H.: "I feel honored and gratefully humble for the privilege of being a Blue Lady and happy as it gives me a chance to express my feelings for our hospital in the only way I can, by friendly services to others . . . I know that I will be a better person mentally and spiritually . . . It is heartening to express our thoughts through our newly begun and fine paper."

Mrs. S., R.N.: "Rosemary comes regularly to ward 6. There is a patient who has ideas about her and spits at her, but Rosemary does not give up and says that she has been sick herself, has had shock treatments, and she wants to help the other patient. Ward 6 is very fortunate to have so many Blue Ladies to help less fortunates."

B.N., (very sick herself), writes: "I want to be a friend to Beatrice F. because she is one who does not exercise well and a walk outside would do her good. She can be cooperative when she wants to be and I am sure she will continue trying to do her best. She has no company and neither do I. I understand the loneliness she must feel in her sickness. I know and Beatrice knows that I'm not her mother but Beatrice needs a friend to confide in and I want to be a friend to her."

H.L. writes: "The Blue Lady meetings are a good idea and beneficial to all of us . . . We can take shut-ins out."

M.A.: "I think I can help other ladies on the ward . . . I know I was recently helped by a Blue Lady. When I was sick, encouragement meant an awful lot."

H.D. writes to a Blue Lady: "I and the others enjoyed the ride in the taxi . . . and the picture was very good . . . I'd like to go with you again."

A nurse from the Geriatric Building writes about a Blue Lady: "She sets hair and adds much to the appearance of a feeble patient . . . It stems from her golden heart . . . Her efforts are appreciated by the confused patients with whom she shows so much patience."

M.R.: "I went with H.D. for a walk . . . took three patients to the dentist, wrote letters for a girl on Ward 4."

Mrs. B., R.N., supervisor of Geriatric Building, writes: "M.S. guides and teaches. Shows an enthusiastic approach to games, music and exercises . . . J.R. works faithfully and assists feeble patients . . . H.R. is busy all the time . . . every patient and employee sings Henrietta's praises . . . A good book is always near her fingertips and she finds time to read it. We are proud to see Henrietta always going about her work."

Of course not all the reports are so encouraging. Nevertheless it is easily apparent that the work of a Blue Lady is just as beneficial to her as to her charges. She gains self-confidence, self-esteem, self-importance, and ability to show warmth toward others. She learns to assume responsibilities and to persevere in fulfilling them. She also feels a part of the therapeutic milieu and gains approval and certain privileges. All these aspects of her work are steps toward better mental health.

Other Steps in Rehabilitation

However, it should be emphasized that participation in the Blue Ladies constitutes only the first step in the hospital's over-all rehabilitation program. Successive steps envisaged but not all fully operative, mainly because of lack of funds, are as follows:

Blue Ladies who prove themselves "well" enough to perform useful work in the hospital 20 to 30 to 40 hours a week should at this stage of improvement begin to be remunerated for their work. For instance, they might be designated as Rehabilitation Hospital Worker-Trainees, in which case they would become eligible for funds from the Division of Vocational Rehabilitation. Theoretically, these patients would be paid $1 an hour for doing the same work they had been doing as volunteers. In reality they would receive only $5 to $10 a week, the remainder being counted toward their maintenance in the hospital and thus giving them the pride of at least partially maintaining themselves.

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Another possibility, already well established in some hospitals, is the sheltered-workshop type of opportunity for patients to receive pay for work accomplished. The main difficulty here is in finding an employer, manufacturer, or owner of a store who is willing to order certain items and arrange for their production in the hospital.

The Night Ward

Patients who have progressed from the Blue Lady to the rehabilitation worker or worker-trainee status should be maintained at this level for six to twelve months, depending upon the individual case. In the meantime, everything should be done to find these patients outside employment, connected, whenever possible, with a return to the family. Should the family be unable or unwilling to accept the patient, then she would be "promoted" to the Night Ward as soon as employment can be found for her. Patients on this ward go out to work during the day and return to the hospital at night, thus avoiding the loneliness engendered by the four walls of a single room. These patients have the privileges of hospitalization, entertainment, medical and psychiatric care, as long as they spend their nights in the hospital. However, their time on the night ward should be limited in order to avoid a too comfortable over-dependence on the hospital.

The next logical step in the program is to give the patient an opportunity to live outside the hospital. For those with families the living situation is simplified. However, for those without families the hospital may have to take the lead in setting up a colony-type situation where groups of three or four patients may live in the same apartment. Such patients should be placed on the same ward for a certain time before release so that they will be well acquainted with each other before moving into the less sheltered situation. Once in the "colony" they should be visited regularly once a week by the social worker and by the physician from the hospital. Supportive group psychotherapy and individual discussions of the patients' difficulties in living should be arranged. Chemo-psychotherapy should be continued. In other words, it is not enough to release the patient into a living and working situation. It is important to extend our hospital therapeutic atmosphere into the convalescent care period.

Hospital Jobs for Colony Residents

Some of the patients released on convalescent care, though well enough to live in a colony near to the hospital, may still not be able to hold a job in a competitive situation. These people should be given the opportunity to live extramurally but to come to the hospital for work as rehabilitation worker-trainees or as trainees in the sheltered workshop, while continuing to receive all the benefits of the therapeutic milieu. Again a careful training program has to be created. These patients should receive one dollar an hour, but no less than necessary to cover their expenses for food and lodging. It is to be expected that they may not be able to "earn" enough, at least at the beginning, and funds should be provided to cover the deficit.

Patients who are able to work outside the hospital should live in a colony near their place of employment but at the same time the hospital therapeutic milieu should be extended to them also. The idea is to place not one patient but a number of patients in a working situation with one employer who will be willing to help and accept our patients as workers, and who will allow for whatever peculiarities or incapacities these patients may have. Some large industries, notably International Business Machines, have started projects of this type.

Some patients might live in colonies and find full employment with one or more employers. There are many well-wishing, understanding people who will give a day's or half a day's work two or three times weekly, provided they do not have to take a former patient into their homes, and provided the patient will be under some kind of psychiatric care and supervision. Here again it is conceivable that patients may not be able to earn enough, at least at the beginning. They should then be considered as trainees, and funds should be found to supplement for some time their earnings to the necessary minimum.

Once a patient becomes self-supporting she may continue to live in the colony, if she wishes, or she may find a job for herself and move to the next and final step in the rehabilitation program—release on convalescent care.

WHAT'S COOKING?

We were leafing through a kitchen catalogue the other day and realized how electrified our private kitchens are becoming. In the typical housing development, the builder may skimp on sidewalks or sewers—but he puts in disposal units, electric can openers, dishwashers, electronic toasters, food mixers, and infrared cookers.

So we went into one of our women's wards and asked some of our senior patients about it. We showed them the pictures in the catalogue. To most of the ladies, the equipment was about as familiar as the control panel of a jet plane. It occurred to us that if we discharged them—and we certainly were aiming to do just that—they could not operate their own kitchens without a course in electronics.

We went to a company that makes kitchen appliances and offered them a sporting proposition. If they would send a demonstrator—and lend us equipment—and show our patients how to use modern appliances without having an engineer's license—if they would do that, they would, as a reward, get a sense of satisfaction. It was a fair deal and they took it. What's more they let us keep some of the equipment in return for a little plate attached to each appliance giving the name of the company. Fair enough?

Then we stumbled on another difficulty. Many of our women were bashful at even trying. We looked up Robert Sommer's article in GERIATRICS (Sept. 1959) and saw this finding: "The women averaged 11 years since they last boiled an egg; 16 years since making soup; 21 years since cooking a meal!" That's how it was with us too.

There's nothing in the psychiatry books about this, but henceforth cooking is going to be a kind of therapy for our women patients. After all cookery is the badge of woman's civilization. No lower animal can cook. Only human beings can do that. Loss of this skill is, in a sad sense, a slipping away of woman's heritage.

Henry A. Davidson, M. D.,
Supt., Overbrook County Hospital
Cedar Grove, New Jersey

NEW PSYCHOLOGICAL TEST

By JOHN H. PORTER, M.D.
Director, Briggs Clinic
Boston State Hospital, Massachusetts

IN VARIOUS PARTS of the country there has been a growing dissatisfaction for a number of years with the psychological examinations currently in use or available for large mental hospitals. The problem has seemed to be one of finding or producing an examination that can be quickly and easily recorded in a uniform manner by each examining psychiatrist; that will be comprehensive both in terms of the objectively observed mental status of the patient and in terms of his current interpersonal and intrapersonal functioning; that can be inserted directly into the record without further transcribing by an already overworked secretarial staff; and that will be meaningful and valuable to any professional person reading the examination at some future date.

With this in mind, the clinical director of the Boston State Hospital appointed a committee (consisting of three senior psychiatrists and the chief psychologist) which was charged with the responsibility of producing a psychological examination that would, in format and in content, satisfy the above requirements.

As a preliminary step, the committee conducted a limited survey of psychological examinations currently in use throughout the country. Fifteen leading psychiatric training centers were contacted and requested to send to the committee copies of the examinations they were using, together with any suggestions or ideas they might have. Thirteen of the fifteen responded. A comprehensive tabulation was then made of all the specific points that were covered in the various examinations, plus the suggested additions and modifications. After screening by the committee, the resultant tabulations plus similar data from the committee members themselves and from the rest of the hospital staff formed the basic core of material that would have to be covered in the new examination.

In order to keep the observations comprehensive, yet easily and rapidly recordable, it was decided to utilize a check-sheet or rating-scale type of format. Most psychological ex-

Part I

(patient's name) (date)

INSTRUCTIONS: Place a circle around the appropriate word for your evaluation of each item. Underline in addition for emphasis of some symptom or quality that is especially predominant.

Appearance & Activity

Appears Stated Age —	Older	Same	Younger
Physically Ill —	Yes	No	Uncertain
(Nature of Illness)			
Neatness and Cleanliness —	Above Av.	Average	Below Av.
In Contact —	Yes	No	Uncertain
Confused —	Yes	No	Uncertain
Posture —	Stiff	Normal	Flaccid
Voice —	Overloud	Normal	Faint
Motor Activity —	Overact.	Normal	Retarded
Speech —	Rapid	Normal	Retarded
(Blocking or Mute) —	Yes	No	Uncertain
Compulsive Activity (Rituals) —	Yes	No	Uncertain
(Nature of above)			

Emotional Responses (Affect)

Depression —	Yes	No	Uncertain
Elation —	Yes	No	Uncertain
Hostility —	Yes	No	Uncertain
Fear and/or Anxiety —	Yes	No	Uncertain
General — E..aggerated	Flattened	Normal	Fluctuates

Content

Delusions —	Yes	No	Uncertain
(Nature of Delusions)			
Hallucinations —	Yes	No	Uncertain
(Nature of Hallucinations)			
Preoccupations or Obsessions —	Yes	No	Uncertain
(Nature of above)			
Speech, Abnormal Content —	Yes	No	Uncertain
(Nature of above)			
Ideas of Reference —	Yes	No	Uncertain
Flight of Ideas —	Yes	No	Uncertain
Persecutory or Grandiose Trends —	Yes	No	Uncertain
(Specify which)			

Sensorium & Intellect

Orientation (Time) —	Yes	No	Uncertain
(Place) —	Yes	No	Uncertain
(Person) —	Yes	No	Uncertain
Memory (Recent) —	Normal	Impaired	Uncertain
(Remote) —	Normal	Impaired	Uncertain
(Retention & Recall) —	Normal	Impaired	Uncertain
Intelligence —	Average	Above	Below
Calculation —	Normal	Impaired	Uncertain
Judgment —	Normal	Impaired	Uncertain
Insight — Yes	Partial	None	Uncertain
Does history or physical examination indicate a toxic state due to:			
Alcohol —	Yes	No	Uncertain
Barbiturates —	Yes	No	Uncertain
Other Drugs (Name) —	Yes	No	
Does history or physical examination indicate any neurological disease other than a toxic state?	Yes	No	Uncertain

M.D.

Part II

(patient's name) (date)

INSTRUCTIONS: Summarize and expand upon the positive findings and the important negative findings of Part I, i.e. more detailed description of delusional system, bizarre behavior, etc. Include here any qualifying remarks you feel are necessary and any symptoms or characteristics you feel were not covered in Part I.

SUMMARY —

M.D.

Part III

(patient's name) (date)

INSTRUCTIONS: Place a check mark in the appropriate column to describe each "character trait" listed below. If you are unable to evaluate it, write across the line "uncertain" and a word or two of explanation, i.e. "not observed, too variable," etc. DO NOT LEAVE A LINE BLANK.

	Excessive	Above Av.	Av.	Below Av.	Deficient
WARMTH—(friendly, responsive)					
DEPENDABILITY—(reliable, trustworthy)					
REASONABLENESS—(sensible, listens to reason)					
PERSONAL APPEAL—(attractiveness to examiner)					
COMPATIBILITY WITH FAMILY—(able to get along)					
TOLERANCE—(to stress, frustration, resilience)					
VERBAL PROPRIETY—(polite, appropriate)					
BEHAVIORAL PROPRIETY—(poise, conformity)					
SELF-RELIANCE—(confident, self-care, independent)					
ASSERTIVENESS—(insistent, defends rights, sure)					
COOPERATIVENESS—(helpful, works with others)					
NEGATIVISM—(stubborn, contrary, irritable, sarcasm)					
COMPETENCE—(ability to get along)					

SUMMARY: (of entire exam if this is admission, monthly, yearly, or discharge exam) (of above character traits only if this is a full psychological exam)

TREATMENT: (since last examination and projected plans and treatment. Psychotherapy, drugs, EST, etc.—Be specific)

M.D.

Part IV

(patient's name) (date)

INSTRUCTIONS: Summarize ENTIRE PSYCHOLOGICAL EXAMINATION. Include all positive and important negative findings and a summary of the "character traits" in one or two paragraphs. DO NOT give specific details of mental content, etc. When presented clearly, concisely, and in a well integrated and organized description of the patient, this constitutes the Case Formulation.

CASE FORMULATION —

PROVISIONAL DIAGNOSIS —

PROGNOSIS — (take anamnesis into consideration also).

M.D.

aminations include one section which is a standard "mental status" examination. This is based almost completely on objective observations and was readily adaptable to the check-sheet format (see Part I). On the other hand, the more subjective part of the examinations that consisted of the evaluation of the patients' intrapersonal and interpersonal functioning was more difficult. It was decided that this could best be recorded in terms of various "character or behavior traits." From a list of over a hundred such "traits," fourteen were selected that the committee felt were most comprehensive and informative, and a rating scale was constructed (see Part III). Both sections had to be carefully constructed and written in order to allow for the least possible ambiguity or misinterpretation by the examiner and for the greatest uniformity and consistency. In addition to the directions on the examination form itself, a set of brief and simple instructions was also written.

Finally, two other sections were inserted into the examination to allow space for summaries, case formulation, diagnosis and prognosis (see Parts II and IV). Because this hospital now uses this examination as part of the admission and discharge procedures and as part of periodic progress notes, using *only* Parts I and III for this, space was provided at the end of Part III for a summary and a treatment outline.

The examination form was completed after a year's work and has now been in use at this hospital for a year and a half. The need for various changes and some modifications has become apparent, but the hospital staff is well pleased with the examination. It has definitely achieved its main goals, and represents a valuable improvement over examinations previously used at this hospital and over those seen in the initial survey. Once familiar with the format, the resident is able to record his examination of the patient in less than twenty minutes. It is comprehensive for both positive and negative findings, and, during this trial period, appears to have enough consistency between different examiners to suggest its use for recording observations for research purposes. Finally, it has proven a tremendous time and effort saver for the secretarial staff since it is inserted in the record directly without transcribing.

At the present time, the committee is preparing plans for a more extensive trial of the examination, and a comprehensive evaluation leading to whatever changes seem indicated.

Staffing Can Be GOOD MEDICINE

By **RICHARD SINGER, M.D.**
Northport VA Hospital
New York

"THE MEDICAL STAFF feels that you are no longer depressed and we are going to recommend that you be transferred to a more privileged ward—."

The patient's face lit up with pleasure and he looked more alive and interested. He had been in a special observation group because of feelings of depression and suicidal ideas. He had appeared before a medical staff to have these feelings evaluated. He was uplifted for several weeks, after which he seemed more eager for eventual discharge.

We have all observed patients responding in this way after a presentation before a medical staff. The effects of the staffing procedure seem to be greater than its administrative purpose would suggest. We sometimes fail to realize that the appearance of a patient before a medical staff can be of therapeutic benefit.

One of the consistent, although not always manifestly evident, facets of mental illness is the patient's desire for individual attention. It is also known that improvement in patients is related to the number of personnel who work with them. This is recognized by hospitals where the employee-patient ratio is almost one to one. Even then, many patients who are withdrawn feel that they are abandoned in the routine of hospital administration and that the medical staff is basically disinterested in their welfare. A patient in a special observation group (mostly potentially suicidal and depressed patients) or an eloper, who does not appear before a staff for long intervals, has these feelings intensified, despite the fact that he is being seen and worked with daily by the auxiliary services. The intensification of feelings of abandonment might be stimulated by the greater security measures on these wards and the patient's sense of incarceration. Despite his defenses of withdrawal, the patient often becomes inwardly angry at what he chooses to think of as medical neglect. This is expressed by an attitude of stubbornness, apathy, and finally a profound sense of resignation. Naturally, since a genuine suicide attempt might result, it is important to keep the patient under maximum supervision—thus perpetuating a cycle. Ideally, a depressed patient should be staffed as soon as the depression resolves, and the patient should be moved to a somewhat more privileged ward. This is a vote of confidence, and impresses him with the fact that people are interested in him and are aware of his changed emotional condition.

Most patients, when one achieves a measure of their confidence, will state they are deeply afraid that they are insane. Superficially, they admit to "nervousness" despite the reminders all around them that they are under close supervision for abnormal behavior. There is often an element of doubt in their minds—"Am I or am I not insane?" Because of an unauthorized absence from the hospital, or because a member of the medical staff feels they are depressed, they are sometimes kept in maximum security and an appearance before a medical staff is required before their status can be changed. A delay in this staffing and their consequent retention under maximum supervision tend to reinforce the feeling that they are, indeed, insane. This resolves their indecision, but at the same time reduces their urge to get back to community life. This and the concurrent acceptance of continued hospital care constitute the path of least resistance for an already damaged organism. Convinced that they belong in a mental hospital, they sink deeper into their chairs and are content to stagnate on a lower psychobiological level.

Show of Interest Provides Motivation

Such an attitude can sometimes be interrupted by having the patient appear before a medical staff. This apparent show of interest often motivates a patient toward increased socialization. A case of this nature was graphically demonstrated by a young man who was markedly withdrawn. He appeared before a staff and was advised to become more active on the ward lest he permit himself to fall into the pattern of a chronically withdrawn individual. This forceful suggestion motivated him to make an effort. He was later transferred to a more privileged ward where his increased pleasures and accomplishments were further incentives for directing his energies outward.

Often a case can be prevented from becoming chronic through such seemingly superficial mechanisms as mentioned above. The unanimous suggestions of a group of physicians seem to carry so much more weight than the advice of the ward physician, with whom the patient is on more familiar terms. We physicians often fail to take advantage of the psychological power which is implicit to our profession. Even psychotic patients are susceptible to forceful suggestion from a person of medical authority—a situation which should engender a sense of responsibility for our remarks to them.

Patient morale is particularly a problem in closed psychiatric wards, but a system of incentives can be utilized to motivate patients. The prompt appearance before a medical staff can enhance and continue the progress of an eloper who has made therapeutic strides. When a patient feels his

efforts are recognized and he is rewarded with increased privileges, he is disposed to keep trying. A case in point was that of a highly assaultive patient who was classified as an eloper. He had been on the same ward for two years because of his aggressiveness and uncooperative behavior. He was told that if he would control himself for two months, he would appear before a staff, which he consequently was able to do. He was staffed, complimented and advised, and moved to a more privileged group. Here he also adjusted and later was considered for gate passes at another staff meeting. Each step forward, achieved through his changed behavior and increased social rapport, was the motivation for subsequent efforts. Conation and the desire to return to society were increased. This, in a vague way, recapitulates some of the factors from which the social orientation of the personality develops.

Nursing Service Also Benefits

A somewhat peripheral therapeutic value of prompt staff action is the effect it has on the morale of the nursing assistants. They are obliged to answer the patients' questions as to when they will be released from the maximum security group. Staffing the patients at frequent intervals provides the ward with the feeling of movement, close supervision, and a sense of team work between physicians and auxiliary workers. Patients despair less, are better motivated, and present fewer problems to the actual running of the ward. In this way, there is a reduction in the psychological pressures on the people who are in most intimate contact with the patients. The nursing assistants fare better when they feel they are part of a dynamic medical team which is smooth-running and strongly motivated toward therapeutic goals. One sometimes finds in patients very definite opinions as to which are the best units within the hospital. Their choices, surprisingly enough, are not always the more privileged wards but rather the most therapeutically active wards—where staffing is included as therapy.

Since a psychiatric hospital is, in effect, a small city of a special character, patients often have a sense of justice and law and order within this framework. They sometimes respond cataclysmically to some episode which involves broken promises, or procrastinations in fulfilling their requests. If the patient has been told that he will appear before a staff, it is important that he do so, even if his condition is such that his administrative status cannot be changed. His failure to be staffed is felt by him to be a rejection by the physician in charge. Because of a basic defect in reality testing, the patient expresses his anger and disappointment in such ways as increased assaultiveness, an accentuation of his depression, or a heightened urge to run away. Promises must be honored as much as possible if the medical staff is to enjoy the respect of the patients—a feeling which is essential for the patient's welfare and the equanimity of the staff.

If one accepts the concept of staff action as a therapeutic effort, one might speculate as to means of insuring its effectiveness. I have always felt that an informal, friendly atmosphere is best adapted to psychotics, who are inclined to become extremely tense while being interviewed. It might be advisable, whenever possible, to avoid the usual arrangement of furniture where the doctors are lined up like apostles behind a long table, flanked by their auxiliaries, leaving the patient isolated and alone beneath their penetrating gazes. A more informal arrangement might help put the patient at ease, thus permitting him to function in a manner typical of his present condition. This would result in a more accurate evaluation, and again the conviction that "justice was done."

Individuality is Stressed

It might be well to offer the patient a cigarette and ask him a few somewhat impersonal questions which are easily answered, in an effort to dispel his anxiety, a not unusual response for an individual who is the focal point for the piercing scrutiny of so many authoritarian figures. Gradually the patient can be directed to more highly charged material, such as his feelings about suicide, his urges to flee the hospital, or his abnormal trends of thought. In the spirit of therapeutic effectiveness, the patient's record should be studied and this familiarity with his life's circumstances should be expressed in the remarks of the staff. This enhances the impression that he is a distinct individual in the minds of the physicians and that they are sincerely interested in him.

Since it is therapeutically important not to cancel a scheduled appearance before the medical staff, a patient should not be told that he will appear unless there is very little chance of a cancellation. Also, it is best to be as frank as possible with the patient during the staffing. If he is to be denied something, it is better to indicate this and the reasons for it. A lack of directness on the part of the staff is sometimes regarded as an indication of "weakness" by the patients, who can often be remarkably perceptive, despite their manifest psychoses. It can be of considerable benefit to indicate the means by which a patient can help himself, for instance, increased participation in ward work, improved personal appearance, and the like. The staff situation is one of stress for the patient and predisposes him to be more suggestible and amenable to a psychological "push."

Elements in Social Management

In summary, staff action can be regarded as being therapeutic as well as administrative in function. If one accepts this, it follows that as physicians we should improve our staffing techniques for the benefit of the patients. Patients can be motivated toward recovery by the expression of staff interest involved at such a meeting, and they can be reassured that progress in their condition will be recognized and the circumstances changed accordingly. The resignation so prevalent among psychiatric patients in closed wards might be reduced by the reassurance, through staff interview, that there is hope for recovery and that, with incentive, they can make strides toward increased privilege and responsibility. When the impact of the staff appearance on a patient is recognized, it can be utilized in the management of many cases. Group morale is improved as patient and staff feel the movement which results from frequent and effective staff action. Better relations with the public occur as patients feel they are fairly dealt with in regard to elopements and depressive episodes. A system of incentives can be instituted through staff action, and patients made to feel that the ward is a dynamically oriented one. It is understood that these factors are not a cure of the basic disease process, but rather are elements in the social management of the psychiatric patient, and the acceleration of his return to civil life.

The Team Approach to Psychiatric Treatment in a Dynamic Milieu

By JOHN M. ALBEA, M.D.,
Southeast Louisiana Hospital, Mandeville
and JOHN V. ALBRIGHT, *Chaplain*
Arkansas State Hospital, Little Rock

THERE IS considerable sentiment to the effect that the present orientation of our state hospitals does not take full advantage of the knowledge that years of psychiatric practice have made available to us. Further, personnel studies indicate that there is no foreseeable increase in the supply of psychiatrists, nurses, and other such critical individuals. It behooves us, therefore, to devise a new approach that utilizes all of our presently available knowledge and personnel in the treatment of patients. The authors propose a team approach in a dynamic milieu, in the belief that it is, at least, a step in the right direction.

Treatment Program

Our treatment program would begin with the closing of the open door policy. All voluntary and court commitment cases would be presented at a "pre-admission conference" so that admission procedures would be more binding and a treatment program could be put into effect on the basic assumption that the people who come here are sick and need some kind of treatment before they return to the community.

The pre-admission conference, which would be attended by the clinical director, section chief of the particular service, social workers, a registered nurse, and possibly a psychologist, would accomplish much of what is now done in diagnostic conferences. Such things as legal residency could be established, and a social case history presented. More important, some evaluation could be made of the seriousness of the patient's mental illness, and a decision could be reached as to whether he should be admitted on a voluntary or a court commitment. Also, assuming that the patient were accepted, it would be decided when he would enter the hospital and to what section of the hospital he would be assigned. Not only is the patient thus being dealt with in a professional way from the beginning, but the section to which he is being assigned is alerted and such problems as high admission rate, over-crowding, etc., are worked through by the hospital personnel in a section meeting before the patient arrives. Thus the patient enters a therapeutic ward rather than a ward hampered by confusion, hostility, and indifference.

To further implement this program it is recommended that there be not just one admission ward for each service but that a patient who is assigned to a specific doctor should be admitted directly to that doctor's ward so that a more detailed work-up of the patient, including diagnosis, a tentative care and treatment program, and a discharge plan, can be instituted immediately. This would eliminate a patient's being in the hospital a period of several weeks with two to four doctors working with him, and his not knowing which is his own doctor. The patient will understand from the beginning that a certain doctor is his therapist, and the therapeutic relationship will be established.

After a sufficient period of time the patient should be presented by the ward doctor at a diagnostic and appraisal conference, which would usually bring together all the personnel on the section: section chief, social worker, chaplain, psychologist, adjunctive therapist, and other interested personnel. This conference would be not primarily for the purpose of having the patient tagged with some diagnostic label, but rather for the purpose of scrutinizing him in the central integrative aspects of his personality and determining the nature of his illness. This would be based on the personality dynamics gained by a developmental history obtained from the patient by the psychiatric resident, by a social case history, by psychological examination where indicated, and by contributing facts from other clinical services such as chaplain, adjunctive therapy, and nursing service.

Following this conference a definitive treatment program would be instituted and designed in a manner to help the patient deal realistically with his illness. Chemotherapy and shock therapy might be needed in many of the cases, but only to make the patient accessible to psychiatric treatment, never to make him forget what brought him to the hospital.

Activities

Each person on the therapeutic team should be made aware of the treatment program scheduled for a given patient so that he can relate to the patient in a way relevant to the treatment situation. Thus, if it is felt that the patient needs love unsolicited, occupational therapy is designed in such a way as to allow him to receive praise and support; recreational therapy would not place him in a competitive situation but would be designed to give him relaxation, a sense of accomplishment, and enjoyment; a task assigned to him on the ward would be a task that could be easily accomplished and for which he would receive praise. On the other hand, if his treatment program called for externalizing unconscious hostility, he would be placed in an unrewarding type of activity, one that would be designed to deal with his hostility externally rather than internally. His occupational therapy would be unrewarding, his recreation would be more taxing, and his complaints about his place in life at the hos-

pital would always be referred to the ward doctor, who would eventually deal with the illness when the patient was able to express outwardly to the doctor his feelings and attitudes. One can readily see that the patient actively enters into the process of working through his illness rather than being a passive agent on which certain procedures are accomplished. This treatment regime lifts psychiatry out of the realm of substituting chemical restraint for physical restraint and dubbing it therapy.

At the diagnostic conference the discharge planning for the patient would be continued so that there would be no period when the family would be closing ranks and excluding him. Rather it would be known from the beginning the exact kind of situation to which the patient would be returning. In the interim the social case worker would be working with the family to see that the program is carried through in cooperation with the hospital.

Each ward doctor would have a weekly team meeting in which the section chief would be present, along with the charge aide, registered nurse, chaplain intern, occupational and recreational therapist, and other personnel. This weekly meeting would make it possible for the ward doctor to deal with the problem areas of his ward. In all probability one patient would be more specifically dealt with each week so that the aides and allied clinical workers would be able to have the support of the doctor, and would be able to support him in the therapeutic program for each patient. This is especially necessary for the patient who seems to be more complicated and unresponsive to the program.

Organization

Naturally, this treatment program has an implication for organization of the hospital. Essentially, the usual administrative divisions would be altered only slightly. The male, female, and criminal services would each be a section. We would hope that eventually there would be a section chief in charge of each section, and that no doctor would have more than one ward. However, in the beginning, for most hospitals the one-ward-doctor idea would have to be held in abeyance, and section chiefs appointed to positions in the hospital as positions could be filled.

These section chiefs would be in charge of an entire service. They would meet with the superintendent, clinical director, director of research and education, and assistant superintendent in clinical-medical conferences. In turn they would hold section conferences in which the different points brought up in the staff meeting would be passed on to the rest of the section personnel, including staff members, residents, social workers, psychologists, occupational therapists, recreational therapists, and, hopefully a musical therapist and chaplain or chaplain intern.

It is only in this kind of program that the allied clinical professions make sense. If psychiatry is a matter of adjusting hormone or chemical balances, then recreation, music, and occupational therapy are just activities to keep the patient busy between medications. If these professions are a part of a planned program of therapy, then we can rightly speak of "adjunctive therapies" and "clinical services."

For the chaplain, as an example, this adjusts the thinking away from the number of religious services, the number of patients attending services, the number of "spot-removing" counseling sessions, and the number of public relations meetings for the sake of public relations. The program then integrates the religious ministry with other ministries and allows religion to be a part of the healing process rather than a refuge away from the process.

Legislative Implications

Legislators and hospital board members would work toward enacting such laws as would allow the hospital to carry through a therapeutic program, with the board's power more on a basis of a board of trustees for buildings and other property. The superintendent of the hospital would be responsible for implementing and explaining the psychotherapeutic program to the board and other interested individuals. In terms of legislation this would mean:

A. *Statutes for Criminals:*

(1) Make the statutes clearly define who can be sent for examination; in other words, not traffic violators, prostitutes, or other persons who commit crimes of a minor nature. (2) Make it necessary for only one psychiatrist of American Board rank to be present at the staffing of a criminal. (3) Send the court a certified copy of the personality profile of the patient with recommendations as to what the state hospital can do for this patient. (4) As long as a small staff exists, make it absolutely unnecessary for a psychiatrist to appear in court in person, except in cases of capital punishment, and then only rarely.

B. *Statutes for Alcoholics:*

(1) Voluntary and Probate Court commitment for ninety days with earlier discharge only at discretion of the hospital. (2) Probate Court Order only if patient gives good and sufficient testimony to the court to the effect that he believes himself to be an alcoholic and wishes to cooperate with the hospital program.

C. *Statutes for the Mentally Ill:*

(1) Voluntary commitment only if the pre-admission conference indicates it is advisable and then for a minimum of thirty days (unless hospital believes earlier discharge advisable). (2) Probate Court Order for an indefinite period —earlier discharge at hospital discretion. Probate Court Order should be issued only with the signature of two licensed physicians who have carefully examined the patient, or on the certificate of a board certified psychiatrist. (3) A seventy-two-hour emergency admission wherein any municipal judge or justice of the peace could have a patient committed on the statement of two physicians or a psychiatrist if the situation constituted a dire emergency. At the end of seventy-two hours the patient would be released unless a Probate Court Order has been obtained from the county where the action originated.

Staffing Advantages

The authors acknowledge that their proposed program is tailored to some extent to fit the circumstances of the usual state hospital. The organizational structure is modified in an attempt to be realistic about available personnel. However, if the philosophy behind the change is adopted, the program will be able to expand and the organizational plan can be adjusted accordingly. For instance, it is thought that this type of program will attract and keep residents and younger psychiatrists. Also, our colleagues in the allied professions will be attracted, and will remain for an indefinite period of time.

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CATRON is a monoamine oxidase (MAO) inhibitor useful in the treatment of depression and of other disorders indicated below. It is recommended for use in carefully selected cases and in those patients who have not responded to the milder drugs.

ADMINISTRATION AND DOSAGE:

Dosage of CATRON must be individualized according to each patient's response. The initial daily dose should not exceed 12 mg. and should be reduced as soon as the desired clinical effect is obtained. A single daily dose in the morning is recommended. A continuous or interrupted schedule may be used, the latter during the maintenance period.

DEPRESSION (Endogenous, Reactive, Postpartum, Involutional, and Depression Secondary to Schizophrenic or Neurotic Reaction): initially, 12 mg. once daily for approximately 2 weeks, or less if improvement appears. Dosage is then reduced to 6 mg. daily. As improvement continues, maintenance dosage of 6 mg. every other day or 3 mg. daily often proves satisfactory. An interrupted dose schedule is recommended for long-term therapy.

ANGINA PECTORIS: 3 to 6 mg. daily in most cases. Relief of pain and elevation of mood may be dramatic. Victims of angina pectoris who respond in this manner should be cautioned against overexertion induced by their sense of well-being.

RHEUMATOID ARTHRITIS (Adjunctive Therapy—in severely disabling forms, particularly when accompanied by depression): 9 to 12 mg. daily for 3 days, then 6 mg. daily, reducing further to 3 mg. daily on signs of improvement. If a conventional antiarthritic agent is used, lower doses of each are indicated.

CAUTION:

Certain circumstances should be watched carefully when using CATRON.

DRUG POTENTIATION—The list of drugs which CATRON potentiates is not yet complete. Hence, caution should be exercised when combining CATRON with any other drugs such as tranquilizers, phenothiazines, the amphetamines, barbiturates, and hypotensive agents.

HYPOTENSIVE EFFECT—Patients receiving CATRON, but especially elderly and hypertensive patients, should be warned about the possibility of orthostatic hypotension during the initial period of higher dosage. In the few instances where this may occur, lowering of the dose will usually permit continuation of therapy.

VISUAL DISTURBANCES—A reversible red-green color defect has been reported in a few patients, chiefly hypertensive, on extended therapy with CATRON. Discontinue the drug if such changes occur. In a few instances, at unusually high dosage, or where the drug was administered following color disturbances, diminished visual acuity occurred which may be partially irreversible.

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SIDE EFFECTS—Major side effects requiring cessation of therapy are infrequent. Other side effects—constipation, delay in starting micturition, increased sweating, hyperreflexia, ankle edema, blurring of vision, dryness of the mouth—are usually readily controlled by lowering the dosage. Rash, observed in a few patients, cleared up rapidly upon discontinuing therapy.

WARNING: Although pharmacologic evidence indicates that CATRON has a selectivity for the brain, it, as well as other monoamine oxidase inhibitors, may cause hepatitis. Because of the possibility of this life-threatening hepatitis, and of the other effects discussed above, the following recommendations and precautions should be observed. If necessary, the patient should be hospitalized to expedite adherence to this regimen.

The Following Precautions Are Recommended:

1. Do not use the drug in patients with a history of viral hepatitis or other liver abnormalities.
2. Perform regular liver function tests.
3. In all instances daily dose should not exceed 12 mg.
4. Reduce daily dose as soon as response is established, usually in a matter of 1 to 2 weeks.
5. Do not prescribe to a patient more than sixteen 6 mg. tablets or thirty-two 3 mg. tablets of CATRON at one time.
6. Patient should return for observation before additional CATRON is prescribed. For this reason, prescriptions for CATRON should be marked, "Not refillable."

SUPPLIED: CATRON is the original brand of pheniprazine hydrochloride. It is supplied in tablets of 3 mg. and 6 mg., bottles of 50.

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—THAT GREW

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The SPORTS DAY—

By J. W. BORTHWICK
Psychology Department
Provincial Mental Hospital and Crease Clinic, Essondale, B.C.

HOW MANY procedures, routines, and events in a mental hospital go on in the same way for so many years that much of their original meaning and value is lost? Most of us working in mental hospitals would probably agree that we continue to do many things in the same old way simply because they have always been done that way. What can happen when we *don't* was well illustrated last July at our hospital when the reorganization of one such traditional event, our annual sports day, blossomed into a remarkable community experience.

For eleven years the hospital has had a sports day for the patients, a day planned by the recreation staff. It has usually consisted of a program of sports, a picnic lunch, a band concert, and an outdoor dance. It was considered originally as an opportunity for closed-ward patients to enjoy a day on the grounds, and through the years it has continued to be just that.

Last summer, however, the recreation director asked at an interdepartmental staff meeting how the day might be expanded to serve a more meaningful purpose for both patients and staff. He pointed out that the majority of patients already had grounds privileges and being out on the grounds no longer had any extra appeal for them. Furthermore, he indicated that except for helping the recreation staff as needed, most of the other staff members felt no particular involvement in the activity.

After considerable discussion of his queries and comments, it was decided to make the day the responsibility of the entire staff. They would be allowed to plan and carry out the day as they saw fit. The usual lines of authority and the usual hierarchy of supervision were to be ignored in the planning of the day, except where they impinged on the usual policies and management of the hospital. No one guessed at that time just what a successful demonstration of the integrated approach to treatment was about to begin.

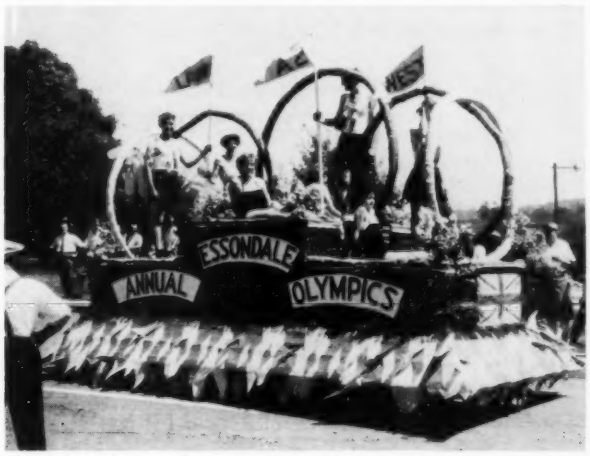
An open meeting was called, to which all interested staff were invited and asked to submit ideas for the sports day. The group then elected a coordinating committee of eight, representing a cross section of the hospital staff, to plan and manage the event. Each committee member became responsible for a particular aspect of the day, and his usual work specialty had no connection with committee responsibility. For example, the track and field events were to be the responsibility of one of the deputy medical superintendents, while food and refreshments became the task of the hospital fire chief. Committee members were empowered to recruit or appoint helpers as they saw fit, with the idea of involving as many of the staff as possible.

There were six main committees: sports, special events, food and refreshments, midway, grounds and properties, and public relations. Out of these grew many subcommittees, each of which was delegated the responsibility for some special aspect of the day. As much authority and responsibility as possible was delegated to these subgroups by the coordinating committee. The general outline of subcommittee plans was to be approved by the coordinating committee but the details were left to subcommittee members. In this way, many of the staff felt directly responsible for the planning and execution of their particular functions. The head of the recreation department became secretary of the coordinating committee and in this role was able to provide a valuable consultative service.

There were only seven weeks to plan the day and during that time the coordinating committee met once weekly for two and a half hours. Without the previously mentioned delegation of authority, the work would obviously never have been completed. The enthusiasm of the staff grew steadily and as more of them became involved each week, plans poured into the coordinating committee for approval. Although most of the costs were covered by money budgeted to the recreation department, various employee groups do-

nated close to four hundred dollars to help provide some of the extras. It was decided to invite the families of staff to participate so that they could become better acquainted with the patients and the hospital.

It soon became apparent that this would be no ordinary sports day. It was developing into something like a small county fair. The theme of the day was to be Western Frontier and all decorations and properties were to conform to the theme. A parade was planned, stage entertainment was



—AND GREW!

arranged, an outdoor barbecue was built, and displays of patients' art work and staff hobbies were prepared.

Concurrently, the recreation, industrial, and occupational therapy departments began involving patients in the preparations. Projects were undertaken in occupational therapy to make decorations for the grounds and the parade floats, and costumes for the participants. Rehearsals for the stage show and pageant began.

Surprisingly enough, when the day came everything was ready. The gala sports day began at 1:30 in the afternoon with a parade which wound through the hospital grounds and past all the major buildings. The route was planned to allow those patients who could not leave their wards to see the parade. Although there were a few outside groups represented, the majority of the entries were from staff and patients. Two brass bands, a Scottish pipe band, and a calliope provided the music for several marching groups, clowns, horses, and 26 floats and decorated cars. Parade judges awarded prizes for the outstanding entries.

After the parade, a traditional baseball game between medical staff and patients began and as usual the patients delighted in beating the medical staff. A program of races and other track events had already been planned but the large crowd of children who arrived from the surrounding community made it necessary to add a great number of extra races for the children so that all would have a chance to win a prize.

The midway ran all afternoon. There were the usual carnival games of skill and chance. To play, it was necessary to have carnival money which had been distributed to all patients a few days before. Each patient was issued five "dollars" and on certain wards extra money was given as a reward for outstanding behavior.

Close to 3000 prizes were given out during the day. Prizes were given not only on the midway but also at the sports events, for entries in the parade, and for contests. They came from a number of sources. Some were purchased and others were donated by local merchants. The hospital volunteers were especially active in gathering them. For example, a local department store donated 300 ladies hats which were used in a hat decorating contest. For more regressed patients there was a balloon decorating contest.

To add to the carnival atmosphere of the midway, a group of Shriners brought a calliope to the grounds. A radio station sent along its mobile broadcasting trailer, and a popular local disc jockey played record requests over a public address system. A local bakery donated a children's carousel for the day. A staff group, dressed in western costume, had a riding ring for children, using horses donated by a nearby dude ranch. For little children there was a nursery where parents could have a baby bottle warmed or let their children take a nap.

The outdoor barbecue was central to the western theme of the day. In a sixty-foot-long marquee, built to resemble a huge chuck wagon, was a charcoal-fired barbecue pit, on which 1800 pounds of beef were prepared. About 5500 meals were served. A number of government officials, local municipal leaders, and representatives of service organizations acted as honorary carvers.

All afternoon and evening continuous outdoor stage performances went on. The performers were staff members, patients, and people from outside groups. The greatest patient participation was in an hour-long western frontier pageant.

During the day, decorated farm wagons were towed around the grounds on sightseeing tours. Social service cars were labeled courtesy cars and the patients could use them for taxi services anywhere on the grounds. A plane dropped leaflets containing lucky numbers redeemable for prizes. In the evening there was an outdoor dance with music furnished by a staff orchestra. The day ended at 10 p.m. with a display of aerial fireworks donated by the employees' association.

Attendance Exceeds Expectations

About 7000 people were on the grounds during that day and only 2500 were patients. There were many more visitors than expected. The majority were families of staff and patients but other people evidently heard about the event and came to see it. Because of the many children who came, it will be necessary next year to provide much more entertainment for them so that they will not crowd out the participation of patients in the events. Several other alterations in programming have been suggested by this year's experience.

The day was a success far beyond early expectations, not only because it entertained the patients but because it allowed the staff to participate actively in new roles. They met and worked with other staff members with whom they would ordinarily have had no contact. A real sense of pride in what they could do was obvious. Talents came to the fore which had never been revealed in the course of hospital routine.

More important from the point of view of the patients, the invitation of staff families helped to break down the sense of isolation from the outside community. Other concrete evidence of community participation, such as that of the disc jockey, also demonstrated to the patients the outside community's interest. The staff itself was pleasantly surprised to find how remarkably cooperative and generous the surrounding community proved to be. Requests for help were answered eagerly, and many voluntary offers were received.

This one event was invaluable in terms of the hospital's public relations. The local press gave the outing good feature coverage. Contacts were made with community leaders and service organizations which will be helpful in the future. All the local businesses and community groups which contributed were sent personal letters of thanks from the medical superintendent, plus copies of the sports-day issue of the patients' newspaper, which carried a full program of the day and gave a good over-all picture of the events, with special emphasis on community participation.

The conclusion reached at Essondale is that the critical appraisal and re-formulation of this traditional event improved its effectiveness many times. The demonstration made clear that being prepared to modify traditional approaches to institutional events and activities will help the mental hospital meet its changing role in society.

FATHER'S DAY VISIT

Hospitalized in an out-of-the-way institution such as the Veterans Hospital in Fort Meade, South Dakota, patients don't get a chance to see their relatives very often.

Father's Day 1959 was the occasion for a reunion of our patients with members of their families. Invitations to attend went out to many parts of the country. Responses were numerous and enthusiastic: relatives of 141 patients came from 18 states; fifteen of them traveled more than 1000 miles, and seven covered some 1400 miles. One family even came from San Diego, Cal., 1480 miles away!

A picnic-style dinner was prepared and served to the 625 participants by the community volunteers. Entertainment was provided by the Fort Meade Drum and Bugle Corps, which demonstrated drills and marching formations.

After dinner a ceremony was held in honor of the fathers hospitalized at Fort Meade. Awards were presented to the oldest father (he was 88), to the youngest father (30), to patients with the largest number of visiting relatives (14 members from the family of one patient on the medical service, and 10 from the family of one patient on the psychiatric service). Special recognition was also given to the families who were present.

Evident, warm, interpersonal relationships were established not only between patients and relatives, but also between families and staff members. Patients felt that their families cared enough for them to put forth the effort of traveling even great distances. A few leaves of absence, some trial visits, and one transfer were arranged as a direct result of this reunion.

James Ryan
Acting Director of Volunteers

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a potent thymoleptic . . .
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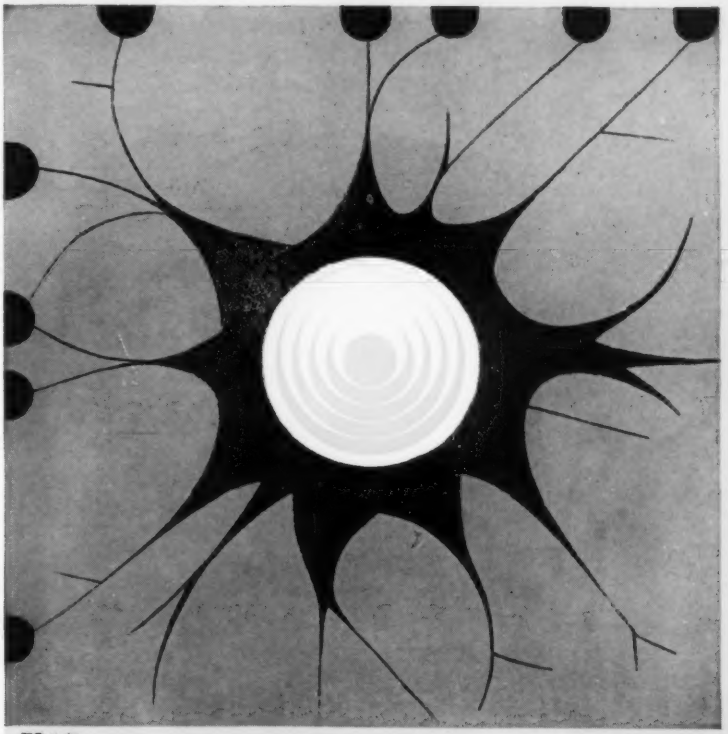
Geigy, Ardsley, New York



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12th MENTAL HOSPITAL INSTITUTE

THE PROGRAM COMMITTEE for the 12th Mental Hospital Institute, to be held October 17 through 20, 1960, at Salt Lake City, Utah, takes pleasure in announcing that the main theme of the meeting this year is to be NEEDS OF THE MENTALLY ILL: TYPES OF EFFECTIVE ACTION BETWEEN THE COMMUNITY AND ITS HOSPITAL FACILITIES.

The opening day of the Institute, Monday, October 17, will be entirely devoted to optional meetings, i.e., the Directors of Volunteers, the American Society of Mental Hospital Business Administrators, the Psychiatric Nurses, the Mental Health Educators, and other groups who request space. Visits to local hospitals will also be arranged for Monday afternoon.

The Institute proper will be keynoted on Tuesday morning by Dr. Jack Ewalt of Boston, Massachusetts, assisted by Dr. Dana Farnsworth, also of Boston. Drs. Ewalt and Farnsworth plan to work together intensively to develop the material.

After the keynote session, the Institute will be divided into seventeen discussion groups—seven consisting of from 40 to 50 people, and the other ten containing 10 to 15 people, depending on the total attendance. Invitations are now being prepared to go to seventeen selected group leaders, who are being invited to formulate, for the approval of the Program Committee, the particular aspect of the main theme which they would like to lead a group in discussing. It is hoped that by this device we will get a good representation of all phases of the material. When these tentative formulations are received, the Program Committee, which is to hold a meeting on May 9 in Atlantic City, will integrate them into the total program for the Institute. Later announcements will give the names of the various group leaders as they accept their invitations.

Simultaneous Sessions will be held on Wednesday afternoon, October 19, and all participants will leave their group discussions to attend. Among those who have already accepted invitations to lead discussions during the simultaneous sessions are Dr. Viola Bernard, director of Columbia University's Division of Community Psychiatry, and Dr. William Hurder, associate director for mental health, Southern Regional Education Board. Dr. Bernard will lead the session on her administrative psychiatry training program, and Dr. Hurder will be the discussion leader for "Organization of Research in Mental Health Facilities: The Experience of the 16 Southeastern States."

Mr. Sidney Spector, on leave from the Council of State Governments and serving as staff director of the Subcommittee on Problems of the Aged and Aging, of the U.S. Senate Committee on Labor and Public Welfare, is arranging the legislative panel to be held on Thursday afternoon, starting at 1:30 p.m. He will co-moderate the panel with Dr. Mathew Ross, A.P.A. Medical Director.

The social program has one interesting novelty this year. On Thursday evening, October 20, there is to be an outdoor barbecue in a famous and scenic location 30 miles away from Salt Lake City. Buses will leave the hotel at 3:30 p.m. so that visitors may appreciate the beautiful drive up the mountain. The price of the tickets will be announced as soon as possible, and it is hoped that many delegates and their wives will attend.

On Monday evening, October 17, there will be an "Early Bird Party" starting about 8 p.m., with free beer and pretzels, and a liquor bar. Tuesday night will be taken up with the Annual Banquet, the presentation of the Achievement Awards, and the Presidential Address by Dr. Robert Felix.

The Institute Program Committee consists of Dr. William S. Hall, S. C., Chairman, assisted by Dr. Alfred Stanton, Mass., Dr. James E. Gilbert, S. D., Dr. Jack Lambert, N. Y., and Mr. James Hodges, Mich. Dr. Albert Fechner is the chairman of the Local Arrangements Committee in Salt Lake City. He will be assisted by Drs. Owen P. Heninger, A. C. Thurman, and Eugene Weimers.

Preliminary programs and registration forms for the Institute, as well as announcements about the barbecue tickets, will be sent as a Supplementary Mailing to all subscribers of the Mental Hospital Service. In addition, they will be mailed as usual in the June Mail Pouch. It should be noted here that those who are coming to Salt Lake City only for an optional meeting of their own group on Monday, and are not planning to stay for the entire Institute, will not be required to pay the registration fee. However, if you are staying over for the Institute proper, the fee will be $50, as usual.

All inquiries should be addressed to the Program Chairman or to Mrs. Phyllis Woodward of the Mental Hospital Service.

A TREATMENT UNIT FOR ALCOHOLICS

By H. L. McPHEETERS, M. D., *Commissioner*
Kentucky Department of Mental Health, Louisville

UNTIL THE OPENING in October 1957 of an alcoholic rehabilitation unit at Western State Hospital in Hopkinsville, Kentucky had no facility especially geared to the treatment and rehabilitation of alcoholics. Yet nearly 10 per cent of all admissions to this one institution alone were alcoholics, who were admitted to psychiatric wards by regular procedure, given only medical treatment to "dry them out," and then discharged.

The decision to open the unit was based on the facts that an alcoholic requires special handling and therapy, that he has nothing to gain from such a brief stay in a mental hospital, and that staff time is needlessly taken up by these patients who wander in and out of the hospital with amazing frequency.

The program began with an open-ward, 21-bed unit for males, which was staffed with psychiatric aides, a nurse, and a psychiatrist, who spent much of their time on the unit. One of the aides had had special training in caring for alcoholic patients.

In its early months, the program was moderately successful, but two major problems became apparent after only a few months of operation. The first came about because many of the alcoholics signed out of the hospital as soon as they were sober, long before they had obtained maximum benefit from the rehabilitation program. We found that this was most often the case with patients who were in the hospital voluntarily or had been admitted on a medical certification. It was also true, however, of the alcoholics who had been regularly committed or sent to the hospital on a 35-day observation order and who were obviously no longer psychotic after recovering from acute alcoholism. Our second problem resulted from the deep resentment that most alcoholics felt at being committed as mentally ill rather than as alcoholic.

To counteract these problems, the staff of the Department of Mental Health met with members of the Kentucky Commission on Alcoholism to draft an Alcoholic Commitment Act which was submitted and passed by Kentucky's Legislature in the spring of 1958. The new law, which became effective that June, provides for a hospitalization petition which can be signed only by the patients themselves, by a member of their immediate families, or by their licensed health officers. A friend, a landlady, a public official cannot sign the petition. At the discretion of the judge, alcoholics are committed to a state mental hospital as *alcoholics* for a period not to exceed six months. Important is the fact that they do not lose their civil rights. Western State is the only hospital designated by the department as one to which alcoholic patients are to be admitted.

As soon as the law became effective, the hospital found itself swamped with admissions of alcoholics. Almost immediately it became necessary to expand the unit, and a 40-bed, locked, alcoholic admission ward was added.

However, public officials' confusion as to the function of the alcoholic program contributed to great overcrowding even in the enlarged facility. Many persons who had no interest in being rehabilitated, or who denied having any drinking problem, were given a choice by court officials: to either sign a voluntary commitment form or be jailed.

To clear up the misunderstanding, the department sent a letter to all county and circuit court officials, fully informing them about the function of the unit. Concentrated efforts were also made to tell the general public about the program through the use of various media—newspapers, magazines, radio, and television. In the early days of the Alcoholic Commitment Act, it took four to five weeks for an alcoholic to be admitted to the unit. Suitable patients can now be admitted on four or five days' notice.

Essentially, the program on the ward combines several approaches which have been found to be successful in treating alcoholics. To help the patients overcome their "shakes" and other symptoms of delirium tremens—rapid pulse, hypotension, hallucinations, intense fear, etc.—they are first given medical treatment. Group psychotherapy, led by a psychiatrist, is part of the program, as is pastoral counseling by the hospital chaplain and by a volunteer clergyman from Hopkinsville. In addition, the patients attend Alcoholics Anonymous meetings held weekly on the ward, participate in recreational group activities, and are given industrial therapy assignments.

Work Assignments Made Early

Interestingly enough, these industrial assignments have proved to be one of the most valuable facets of the program. Just as soon as the patient is able to begin work, he is assigned as a food server or an assistant to the psychiatric aides on continued treatment wards. This gives him a strong sense of being useful and needed, and he has an opportunity to observe patients who are permanently hospitalized for brain syndromes resulting from chronic alcoholism. It should be pointed out that this consequence of continued drinking is presented to the patients in no other way unless they themselves bring up the question.

A considerable percentage of patients at Western State are problem drinkers for whom no other facility exists, persons who are economically and socially between "bums," and those who can afford a private sanatorium.

From observation, the alcoholic patients at Western State generally fall into three categories:

(1) Symptomatic drinkers with underlying psychoses or psychoneuroses. These patients are encouraged to accept treatment in the regular psychiatric wards of the hospital, and many do so. Generally speaking, we have been successful with this group.

(2) Primary addicts who have been drinking since their youth and who go on binges with increasing frequency. These patients have typical, strong, oral, dependent strivings which are met less adequately by the program. Results with this group are much poorer than with group 1.

(3) Secondary addicts who have been successful in their lives until some reverses led them to excessive use of alcohol. The rehabilitation of these patients has been relatively good.

A follow-up study was conducted on the first seventy-five patients admitted to the unit prior to the passage of the Alcoholic Commitment Law. It was discovered that many of the patients who were studied had signed out of the hospital long before they had received maximum benefit from the program. In spite of this, the survey's results are gratifying: approximately one third of the seventy-five had remained dry for the total follow-up period (at least three months); one third had controlled their drinking within acceptable limits; the rest had resumed drinking.

Under the law governing them, alcoholics must now stay in the hospital until released by the staff. As a result, the department expects an increase in successful rehabilitation. Actually, the average period of hospitalization has been seven weeks; only a very few patients are kept the full six months permitted by law.

Some have questioned the department about the reason for an involuntary commitment procedure when it plans to discharge patients who show no inclination to be rehabilitated. The department feels that this procedure is needed for those persons who have a problem, who admit that they have a problem, but who will not seek help voluntarily. We have found that after such patients have been committed by their families, they generally prove to be cooperative in the hospital.

We have been greatly pleased with the acceptance the unit has received. In two communities new Alcoholics Anonymous groups have been organized by ex-patients from Western State's rehabilitation unit. In spite of severe limitations of understaffing, and the lack of a unit for women, we feel we now have a more effective clinical and administrative means of treating those alcoholics who come to the hospital fairly regularly even though they are seldom psychotic.

The hospital expects to make the entire unit an open one when the problem of receiving patients who take advantage of the first opportunity to escape has been satisfactorily curtailed. As an important corollary, the admission wards at Western State as well as those of our other three hospitals have been relieved of the constant annoyance of the people who characteristically came to the hospital begging for admission and then four or five days later demanded their release only for the cycle to be run over and over again.

GROUP THERAPY IN A RECEIVING HOSPITAL

By LIONEL FINKELSTEIN, M.D.
and IRVING BERENT, M.D.
Detroit Receiving Hospital, Michigan

TO THE PSYCHIATRIC WARDS of Detroit Receiving Hospital comes a steady procession of attempted suicides, acute and chronic alcoholics, psychotics, seniles, narcotic addicts, most of the city's severely disturbed psychiatric emergencies. These patients rarely stay at the hospital for long. Some are treated briefly and discharged; others are released to be seen in the outpatient department; others are sent to the convalescent homes, state hospitals, or private psychiatric hospitals.

This, then, is the setting in which we decided to try group therapy. However, since most patients could attend only one or two sessions, we could not think of using the methods of the usual continuous group psychotherapy. Here things happen either quickly or not at all. There is no time for the development of characteristic relationships between members of the group and the leader. For this reason we were forced to find new ways of dealing with the group. Our final method evolved out of experiments and failures as we went along.

We began with one doctor acting as the leader of the session and another doctor acting as the observer. A difficulty that arose from this was that the leader was faced with the job of maintaining a conversation alone. If he was too lively or forceful, all the remarks would be addressed to him, and the shyer patients would then lapse into a dismal classroom silence. If the leader was quiet or passive, then a more disturbed patient would take over the meeting with a psychotic monologue, while the others gazed about nervously. Even with both doctors running the show things remained stilted, and the problem of several people talking at once was a frequent obstacle to group discussion.

Finally, we decided simply to join the group much like hosts at a party. Anyone there, including nurses, interns, or orderlies, as well as patients, was invited to join in any role he might choose. Several might speak at once. We invited discussion of any topic, but especially criticism of the ward. The arrangement relieved the doctor of sole responsibility for the success of the meeting and it freed the others from the burden of having to listen to one speaker. We all became more spontaneous and we found the meetings became more pleasant and successful.

Because we felt that there would be common problems for different stages of life, the patients were divided into three groups according to age. The age groups were thirty-five and younger, from thirty-five to fifty, and fifty and older. No other criteria were used in selecting patients. If the patients could walk or could come in a wheel chair, he was invited to the meeting. We met in the ward dining room and served fruit juice in paper cups, which lent a poor but genteel air to the gatherings. A meeting with no refreshments failed dismally.

The doctors, having given up the cloak of authority, were obliged to develop subtle techniques of conversation if the meetings were to be successful, and the goal of the meetings was always a spirited and revealing exchange of ideas. It was important for the doctors to learn to draw people out, to listen carefully, and to comment tactfully. Development of conversational finesse which could also help in doing individual therapy was only one of the ways in which the meetings proved profitable for the doctors.

Doctors Gain New Knowledge of Patients

The sessions became a sort of diagnostic laboratory test, in which the patient revealed new dimensions of his personality. For example, an angry and delusional colored woman began to chat with a rather feminine patient in such a tender and gallant manner that her homosexuality became obvious. Before the sessions we could only guess that she might have such feelings. Her gentle solicitousness, furthermore, made her inverted love appear more human, less a psychopathological phenomenon.

At another meeting, a disturbed patient, who had been clamoring for attention, began to take off her clothes. She would have undressed herself completely if the other patients had not stopped her. When one of the doctors interpreted this to her as a way of getting attention, she replied that he was right and then she related what no interview has revealed. Her husband had been ignoring her and going out to drink every night. She had been at home becoming more and more disturbed and finally, frantic for attention, she had run naked into the street. This was the episode which caused her to be brought to the hospital.

In the first case, the patient revealed an essential trait of

her character; in the second case an important bit of personal history. In both cases, we obtained information spontaneously in the group setting which had not appeared and probably would not have appeared in many personal interviews with the patients. The group situation stimulates revealing behavior from which an alert observer can learn a great deal.

Group Action Provides Index for Disposition

Knowing as much as possible about his patients is important to the doctor because he is always pressed to decide where a patient should go. For example, can an old man get along in a nursing home where the atmosphere is more pleasant and where he will have fewer controls, or will he need the security of a state hospital? Many times we could see that a hopelessly confused and delusional patient got along well in the group, while another patient, whose thoughts were more clear, was so disagreeable that others found him intolerable. We found we could often decide best in a group session whether or not a patient should be allowed to remain in society, since one's ability to relate with others is more important in such a decision than is the content or quality of his thoughts.

The meetings educate the resident psychiatrist in other ways. They help him to become more worldly, for instance. Our patients are poor, generally, and come from marginal areas of society. Their world and their experiences are different from those of the doctor. This was demonstrated clearly when one of our doctors commented, in talking with the middle age group of patients, that he felt boys were harder to raise than girls because boys were wilder. The group, consisting of six poor negro women, disagreed. They felt that raising girls was more difficult because girls were continually in danger of sexual assault. Surprised, the doctor asked the women if they had had such experiences and each of them stated that as a girl she had been attacked, or at least annoyed frequently by older boys and men in her family and social circle.

The point is that the doctor was surprised at the ways of the patients' world, and as long as the patients' world was strange to the doctor, he might stay aloof from their problems. When he became familiar with their problems and began to imagine how he might feel in their position, he became more able to really help them. In addition, the doctor was often made aware in the meetings, of the patient's experiences on our wards. Even though he worked on the ward, he might have ignored the steel benches, the plain walls, the bars on the windows, and the broken television set had these things not been stressed over and over in the relaxed atmosphere of the group session.

Patients Benefit from Socialization

The meetings offered the patients a sociable and democratic experience. A patient on our ward may sit in a corner and stare at the floor for hours. Often he is a person who has avoided human contact before he came to the hospital. He is, in addition to being withdrawn, monotonous and patterned in his behavior. In our gatherings we saw patients begin to come out of their shells and sometimes we even saw them trying new ways of social behavior.

A touching moment occurred when a woman who had avoided everyone for months was asked to pour the fruit juice. She accepted the challenge and with a trembling hand was able to do what was at first a terrifying act of sociability for her.

At another session two of the livelier patients had proposed to have a show on the ward. The doctors suggested that they have tryouts right then. One extremely shy patient, who had been able to talk only with her own doctor, suddenly offered to sing in the show. She gave a poignant but off-key rendition of the Lord's Prayer. There was general applause afterwards and the patient beamed as if she had attained a major social triumph.

Even for those who do not participate, most often for older people who have lived alone, there is a feeling of pleasure in belonging to a group. One very old lady stated that she had nothing to add to the conversation but she appreciated being "out in company." An ancient blind woman was brought to a meeting in a wheel chair and when she began to cry out in her confusion, a nearby patient began to rock her wheel chair much as one would comfort a baby. The two patients related together as mother and child. We often see patients treating each other spontaneously on the ward, but it appears more striking in the group situation.

In these examples the group setting opposed regressive withdrawal by the patient. In contrast to individual psychotherapy the emphasis is on relating to many other people in any way possible for the patient. There was a great difference between the pouring of tea at a party and the primitive way the blind woman joined the group. But in all these cases we saw a lonely person extending himself to join others, perhaps even to learn new ways of acting, as did one timid woman who was herself able to express a bit of anger for the first time when she saw an irate patient scold the doctor.

Educational Material Included

Occasionally our sessions also have educational value for the patients. At one meeting contraceptive devices became the topic of conversation. We discussed which methods were safe and which were dangerous. At other times we talked about disciplining children and discussed various problems with in-laws. The tone was never intentionally didactic but sharing experiences seemed useful for some patients. In some cases, however, the patients were not helped but instead were frightened by the material discussed. Pregnancy and childbirth became the topic of one session and a childless woman, who had been listening carefully up to that point, became so uncomfortable she left the room. The door was always open for the patients to escape, and often the time when a patient left was more revealing than anything that was said.

We feel, in reviewing our experiences, that group meetings are worthwhile in an acute emergency setting. We evolved a type of sociable meeting in which there was no leadership and no plan of action. The effect was to emphasize warmer contact between those present. The meetings became a humanizing experience in a hospital which easily tends to be cold and drab. This feeling was expressed best by one of our patients. We would thank the patients as they left the dining room. On one occasion an elderly and slightly confused man who had been to a number of meetings took over our role. He shook each doctor's hand gravely and said: "It's been nice seeing you here and it surely was a pleasure to get together and talk a bit."

Good Grooming

Patient who was named "Mr. VA" in the Good Grooming Program, displays the new fall suit of clothes as he accepts his trophy.

Summer suit is modeled by a patient from the continued treatment service.

By A. R. ASHLEY,
Chief, Patients Effects Section, Registrar Division
VA Hospital, Tuskegee, Alabama

THE patients effects section of the VA Hospital in Tuskegee, Ala., spurred by a study and recommendations made some years ago by the American Psychiatric Association Mental Hospital Service Committee on Clothing, launched a "Good Grooming Program" for the patients last spring.

Realizing that there is a direct relationship between the patient's adjustment and the way in which he is clothed, this section set up the project to promote habits of good grooming and personal hygiene, and the maintenance of continued interest, pride, enthusiasm, and participation. We feel that by providing not only interesting information on clothing and the accepted use of combinations and accessories, but also a selection of decent clothing, we may be able to motivate and stimulate the patients to take more interest and pride in their personal appearance.

The program began in March 1959, with a "Spring and Summer Fashion Show," highlighted by the appearance of a well-known model who gave the patients helpful tips on appropriateness of dress.

We are happy to report that, after much planning and education on the part of both the nursing service and the members of our own section, progress is being made in the general appearance of our patients. Although the good grooming program was designed primarily toward a "new look" in the appearance of privileged patients, we have noted much pride, enthusiasm, and participation on the part of even our closed-ward patients. It is particularly noticeable among those who are permitted to attend special activities on and off the station.

Most of our privileged patients with funds are now purchasing their clothes under our layaway plan. Permitted to select their wardrobe items, they get added pleasure in spending their own money. The Veterans Administration provides each indigent patient with a suit of clothing for summer and one for winter. Like all others these patients can avail themselves of the services of the hospital's storekeepers, who will assist them in selecting a suit and accessories, such as shirts, ties, and shoes, in a variety of styles and colors, to satisfy their individual tastes.

We believe that the Good Grooming Program has done much to encourage and improve the patients' personal appearance. They seem to exhibit new pride and dignity as they go about the hospital grounds.

Patient and volunteer date from Tuskegee Institute wear sports attire.

STAFF DEVELOPMENT

By WILLIAM F. BANAGHAN, Ph.D.
Supervisor of Student Affairs
Southern Illinois University
Alton, Illinois
and HUGH McLEAN
Field Counselor
Midas Muffler Co.
Dallas, Texas

PRIVATE INDUSTRIES have long recognized the need for better administrative procedures, and have developed programs aimed at increasing their effectiveness. So too, the administration of Napa State Hospital* in Imola, California, has recognized the need for improvement and has supported a staff development program with the hope that hospital personnel will become more effective in their supervisory as well as in their personal relationships.

The program was initiated during the summer of 1957 with the assistance of the Training Division of the California State Department of Personnel. The first staff development conference, which lasted a week, was attended by the superintendent and nine members of the hospital's top administration. This was followed by two similar conferences for personnel at the department-head level.

Ten hospital employees from a variety of occupations were then invited to attend a conference aimed at the development and practice of skills necessary to the organization and administration of a training program. Upon completion of the conference, these employees, called "trainers," made plans for a training program aimed at improving the effectiveness of supervisory and professional personnel.

Because there are some 1500 employees, most of whom have supervisory functions over employees or patients, the initial program was limited to people in the professional classifications and to supervisory personnel at the ward-charge level and above. After considering the number of people in the various occupations concerned, it was decided that each group should have ten members; four from nursing service, two doctors, one social worker or psychologist, one person from the rehabilitation services, one from maintenance, and one from one of the occupations with few employees in the hospital.

Each group was scheduled to meet eight hours a day, Monday, Wednesday, and Friday, for a two-week period. During the two weeks, the group members were released entirely from their duties on conference days. The trainers were released from their duties for the entire period of time plus two days before the conference began.

Several articles on administrative subjects were reproduced and assembled into manuals, and distributed to the participants. In addition, audio-visual materials such as blackboards, projectors, posters, and tape recorders, were acquired for use in the training portions of the program.

The development conferences were designed to give the members direct experience in a variety of one-to-one and group interrelationships. On the first day the trainers usually presented broad goals and suggested methods of arriving at these goals, but thereafter the atmosphere was quite permissive and the group could reject the manner of achieving the goals, or even the goals themselves.

The trainers attempted to produce the following conditions which were felt to be conducive to changes in behavior: First, each member had responsibility for influencing the direction and extent of the group movement and, if the group agreed, for conducting an interview and a subconference. Second, a relatively high emphasis was placed on observing and considering the verbal and non-verbal behavior of group members, and the responses of the members to the observed behavior. Third, the members, both as individuals and as a group, had the opportunity to evaluate the purpose and effectiveness of several forms of interpersonal behavior. Fourth, many of the participants, both members and trainers, could become, for the first time, aware of several of their own patterns of behavior which were seriously ineffective.

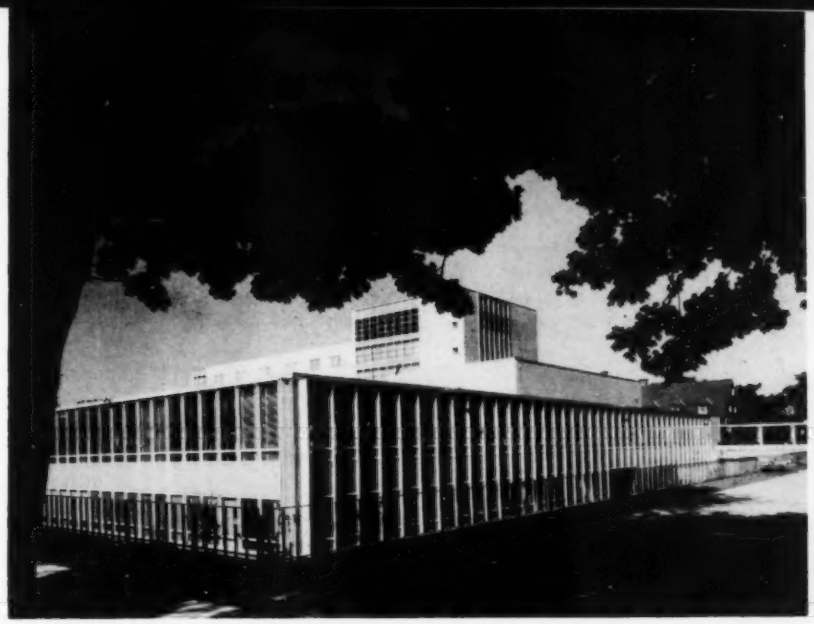
Goals and Results

From the beginning of the program the trainers recognized the need for a rigorous evaluation in terms of the specified goals of the program and the results achieved. Unfortunately, the time and energy of people skilled in such evaluation either were unavailable or were expended in the organization and development of the program. In the opinion of the superintendent and outside observers, however, in general it has been quite successful. At the completion of the first phase in October, 1959, a total of 250 people had attended the sessions. It would be false to assume that the results were panacean, but there is some evidence for the following conclusions:

1. Personnel are more ready to accept change.
2. Better interdepartmental relationships exist among the various hospital disciplines.
3. A more positive attitude has developed with a corresponding decrease in the negative attitude.
4. New skills have been acquired; people have become good listeners and improved their supervisory techniques.
5. Role-leveling has occurred. Stereotypes of personnel in work roles have been broken down and individuals are being perceived as persons rather than as "heads of departments" or "employees."
6. Changes in relationships to management have resulted in a greater tendency toward a *We* rather than a *They* viewpoint.
7. Better communications relationships have developed among a large proportion of the personnel.
8. Predictions of the effectiveness of people as group participants can be astonishingly inaccurate. Sensitivity and skill in interpersonal relations have become apparent in individuals where these characteristics were not previously recognized.

**At the time this article was written, both authors were serving as clinical psychologists on the staff of the hospital.*

By
CHARLES E. GOSHEN, M.D.
Washington, D. C.



FENESTRATION

UNTIL RECENTLY, the wide use of glass in construction was almost exclusively restricted to the most expensive buildings. Fabrication and transportation problems made the production of large glass sheets impossible, excessive glass areas reduced heat retention, and large window spaces weakened the structural elements of the walls. Furthermore, people did not fully realize that with large and numerous windows they could benefit from the many healthful and sanitary properties of sunlight. Bound by these limitations, glass became a luxury item and, although well-established as an art, glass-making for construction purposes was deemed impractical.

In contrast, today's building designs cannot afford *not* to include glass or its substitutes in all their various forms. The problems of overcoming costs and technological limitations, together with the public demand for modernization, have prompted architects to investigate all types of fenestration.

The New Look

Almost every new building makes generous use of glass in windows, walls, skylights, and ornamentation, for any number of aesthetic and sanitary reasons. In fact, glass has become a yardstick of modern construction, and the vintage of practically any office building can be determined by the extent of glazed wall area. Similarly, the renovation of old buildings often begins with a radical change in fenestration, and much of the value of the resulting product is determined by the degree to which glass or plastics have been employed. Leading the trend are office buildings, which are followed closely by schools, banks, shopping centers, and private homes.

Mental hospitals have been somewhat slower in realizing the potentials of glass. Unfortunately, the designers of our institutions are more likely to be impressed with the fragility of glass than with its healthful and therapeutic benefits. Yet there are few types of structure so in need of minimizing the opacity of their walls as mental hospitals. Good psychiatric care requires that we create every possible incentive to encourage the patient to work toward making his way outside the hospital; a realistic step in that direction is to offer him an actual view of the surrounding terrain.

Just as the patient needs to be able to see what is outside, so the public wants to see in. If the hospital can convey a picture of sunniness and openness there will be less of an aura of mystery surrounding it. A dressed-up entrance can convey a favorable impression to new patients and to visitors. Large glass doors, sizable windows, and glass and plastic decorations all combine to make the building more inviting. The store with large display windows attracts more customers than one with none; the hospital can offer a much warmer welcome by limiting its opaque wall areas.

By the same token as the entrance is important to visitors and newly admitted patients, the rest of the hospital should be constructed with the patient and staff in mind. The distribution of glass surfaces on the wall of a building should be closely related to the position of the building on its site.

An inviting glass entrance immediately conveys an impression of warmth and openness to visitors and new patients.

By erasing one wall with a large window, this bedroom was made to look much larger than it really is.

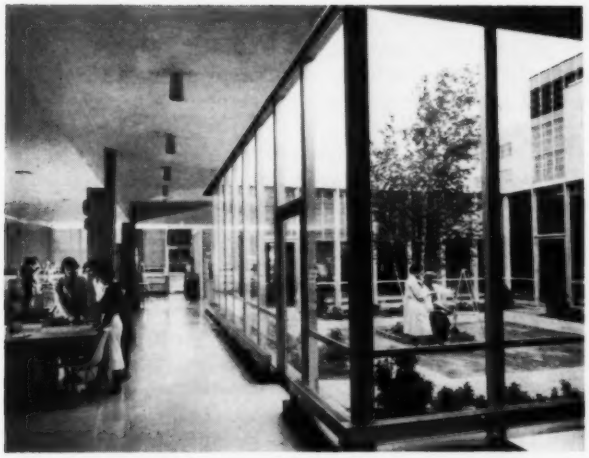
This entrance features an aluminum-louver type of sun control device which also acts as an insect screen.

When looking at the blueprint of a hospital it is all too easy to lose sight of such factors as the direction of the sun, which way heavy winds and rains usually come, and what sides have the good or bad views.

The altitude of each floor of the building is also an important factor in determining how to place the windows. High windows will hide an unattractive view, and still admit the sunlight. In tropical and semitropical areas, overhangs and recessed windows reduce the amount of hot sunlight without eliminating the view. Hospitals located in areas with long sunny summers can make use of casement-type windows on their southern sides, and reserve their northern walls for larger, picture windows. Those in northern climes will want to capture every possible ray of sunlight, and so it will be best to allow for maximum wall area facing south, shutting out as much of the cold northern skies as possible. In most parts of the country, unsightly metal bars and other window coverings of the past are being replaced by safety glass or heavy-duty plastic.

A completely glazed wall was utilized in this dayroom to capture an inviting view of the outdoors.

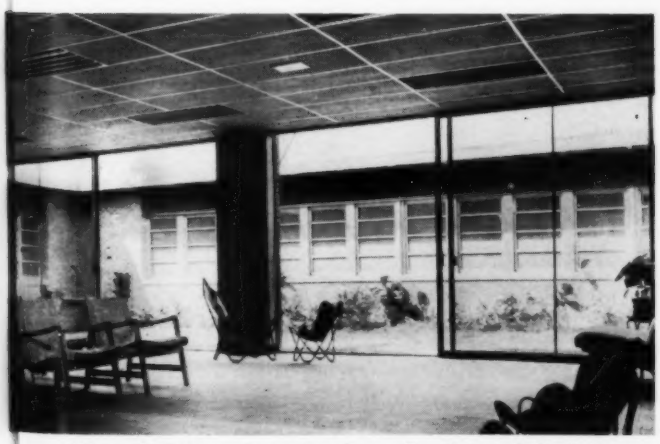
The amiable and relaxed atmosphere of this modern waiting room was greatly enhanced by the use of glass.



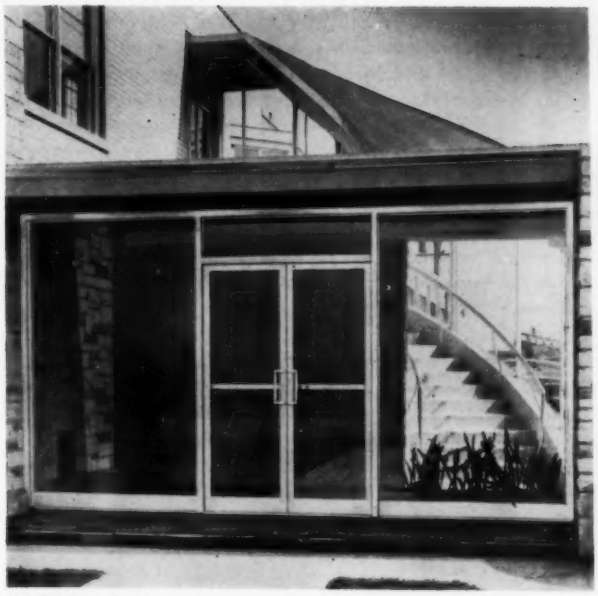
Glass panels enclosing a small central courtyard allow invigorating sunlight into an adjunctive therapy area.

Overhead windows are another alternative for making full use of sunlight. These can be glass or plastic, transparent or translucent. Plastic materials come in all shapes and sizes, and can be used for skylights or to cover an entire roof. These features, of course, are particularly applicable to the single-story structure. They afford a greater amount of over-all sunlight than do wall windows. Glass doors, glass-brick walls, and Fiberglas panels are exceptionally useful as dividers which do not interrupt light. Corridors which are apt to be dimly lit and devoid of visual outside contact can especially benefit from these interior surfaces.

No longer is the mental hospital planner limited in his consideration of transparent areas. Glass and its substitutes have led the way to intricate design through improved technology. Free and correct placement provides beauty, sanitation, and convenience, and fits well within the construction budget. It is wise, therefore, to consult not only with architects, but also with manufacturers about the mechanics of proper fenestration.



Through the use of exterior glass walls, the psychological difference between outside and in can be greatly reduced.



With the addition of a modernized glass entrance, an old building takes on a refreshing new look.

Interior Fiberglas partitions are attractive space separators that provide privacy without obstructing light.

REVIEWS & COMMENTARY

READERS' FORUM

A Question of Statistics

I would recommend that Dr. King (MENTAL HOSPITALS, December 1959, Page 16) visit the Chestnut Lodge sometime. He will recognize that the staff there is getting improvement in 48 per cent of everyone else's failures, i.e., almost half of his residual 30 per cent.

He might also ponder findings that:

(1) Statistically, first-year residents get more patients out of hospitals faster than any other psychiatric group;

(2) Almost 70 per cent of the first admissions everywhere get out of the hospital—for awhile at least;

(3) The Massachusetts Mental Health Center reports an improvement recovery rate well over 90 per cent.

H. M. Murdock, M.D., Medical Director
The Sheppard and Enoch Pratt Hospital
Towson, Md.

Safety In Numbers

The psychiatric interview is coming under the control of the punch card. In the November 1959 MENTAL HOSPITALS (page 52) is the story of how punch cards save time in a psychiatric clinic. "Every bit of information we normally record," writes the author, "is put on IBM cards." Every bit, doctor? Can the feeling tones be reduced to numbers? Is there a spot on the card for hostility? When a "person becomes an active case" (what a curious way of depersonalizing a human being!) "names are abandoned and case numbers are used." There are yellow cards (for openings), blue cards, and finally green cards which are for "problems." (No, I am not making this up).

On the yellow card "*every* background factor is punched." Every one! The three colored cards together, says the author, "form a succinct record of *every* factor the worker may need." The system, we are told, relieves the worker of the time-consuming work of transcribing notes.

By no means the least advantage, writes the doctor, "is the availability of the records for the compilation of monthly reports." Another advantage is that it aids research. The cards, he says, "have unlimited value in the area of statistics."

So falls that last bastion of individuality: the psychiatric interview. Once this was the point where nuances of feeling were more important than cold facts, where the one-to-one contact was permitted without the rigidity of a preconceived structure. As the idea spreads we shall all become card-punchers, for the system will aid research, give us wonderful statistics, and help us compile monthly reports. No one seems to have said whether it will relieve anxiety (either in the patient or in the therapist) or tighten the mystic bonds that hold people to each other.

Well, it was bound to happen. The punch cards, once the work of the mind of man, are now turning on their makers and reporting on the mind of man. The system must be a great comfort to the unimaginative therapist who cannot transcribe feelings into words. He feels safer if he can punch-card it. That is what is meant by "safety in numbers." Maybe that too is what Longfellow had in mind: "Tell me not in mournful numbers, life is but an empty dream. . . ."

Henry A. Davidson, M.D., Supt.
Overbrook County Hospital
Cedar Grove, New Jersey

Conference Consternation, or Semantica Revisited

During a recent safari to Semantica, my colleagues and I were intrigued but confused by our widely varied assessments of the local flora and fauna. The leader and the historian of the expedition oft bemoaned the problem of recording each day's events and discoveries.

The diverse expedition members had great difficulty agreeing on just what they had seen and heard; a member would, for example, bemusedly pursue an interesting nuance until

he had become hopelessly lost in the dense surrounding adjectival underbrush. In such an unfortunate eventuality, we dispatched rescuing guides, of course. But occasionally even the guides lost their way and spent precious hours beating around the bush.

Our problems were not lessened by the dangerous unpredictability of the verb and noun fauna. Sometimes they would be dormant and one could aproach them safely, but at other times they charged without warning, crashing through the adverbial verbiage. More than one expedition member suffered real and/or imagined hurt as apparently quiescent words bit back with unexpected venomous ambiguities.

Imagine my surprise on returning home, therefore, to find that previous explorers, similarly to Linnaeus and Baedeker, had compiled and described their journeys through Semantica very well indeed. As a scarred member of several such expeditions, I recommend to all future explorers and their parties these volumes: Webster's New Collegiate Dictionary and the Dictionary of Contemporary Usage (B. & C. Evans-Random House). Some member of the expedition, armed with these guides, might be designated as lexicologist. He would quickly become worth his weight in time to his fellow explorers, and equally important, might be able to delineate the way for later historians to describe his expedition in terms of concepts and actions arising from it.

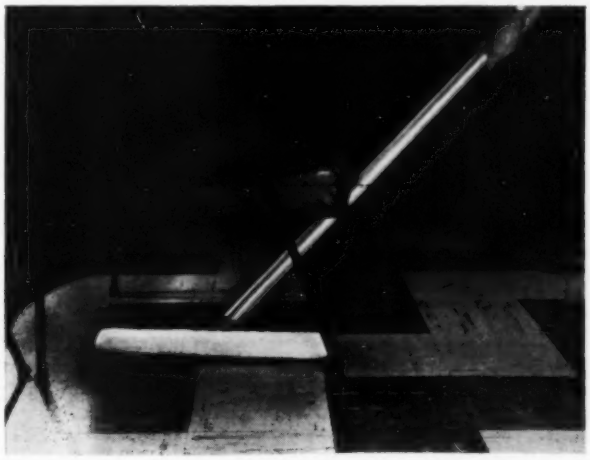
Thaddeus P. Krush, M.D.
Clinical Director, Community Services
Nebraska Psychiatric Institute, Omaha

NEW PRODUCTS

Spring is traditionally "spruce-up, paint-up" time, and while efficient housekeeping and maintenance are a day-in, day-out chore, rating our most meticulous attention, it seems timely to discuss two new products for these purposes.

Automatic Wax Applicator

Power-Flo Tools, of Pittsburgh, Pennsylvania, has a new automatic-feed wax applicator with a "flip-over" head that allows it to be tilted to almost any angle to get under and around obstructions, as shown in the accompanying illustration. The unit speeds waxing since it completely eliminates the time spent dipping an applicator in a dip pan or spreading wax from a container. Wax is saved since there is no contamination of clean wax with a dirty applicator. Almost a quart of floor wax is stored in the aluminum handle. An economy in both time and supplies, the unit retails for under $7, and inexpensive replacement covers are available from the manufacturer, Power-Flo Tools, Box 221, Pittsburgh 30, Pa.



Self-Feeding Painter

Our next product is also self-feeding, the Admiral Painter —not a "crutch" for lazy painters—but rather another of the time and material economies which merit consideration. The automatic air pump and hose feed paint into the roller; all surfaces, rough, smooth, or stipple, are quickly and completely covered, and as the roller is fed only as much paint as is needed for the particular point of contact on surface, messy dropcloths and cleaning-up are eliminated. Portable, it may be used inside or outside and is a completely self-contained unit, the tank holding three and one half gallons of paint. It sells for $49.50 and is manufactured by the Grigsby Company, 1204 "K" Street, N. W., Washington 5, D. C.

Alexis Tarumianz

BOOK REVIEWS

FIFTEEN INDICES: AN AID IN REVIEWING STATE AND LOCAL MENTAL HEALTH AND HOSPITAL PROGRAMS—Joint Information Service, American Psychiatric Association, Wash., D. C., 1960, 86 pages, $2.

The Joint Information Service has brought together important data on 15 indices of significance to hospital administrators, to legislators, and to citizens who follow the progress of the mental health program within their own state. It is most important that a person using this document read the text, particularly on page 3, and the text also included with each of the charts. Perhaps not sufficiently emphasized in the text are precautions that must be observed in drawing conclusions based on a statistical comparison of the program of one state with that of another. Of greatest value in this compilation is the material enabling interested persons to check the changes and the direction of changes in their own states. For example, citizens in Vermont can learn that the percentage of physician staff adequacy in their hospitals has decreased in 1958 as compared to 1956, while Virginia has shown an increase or improvement in the physician ratio during that same period. Trends in directions of programs might be further demonstrated by the fact that Kansas has a high physician staff adequacy in its hospitals as compared with Massachusetts. However, in Kansas the professional hours and clinics per 100,000 population are lower than in Massachusetts, and both are increasing. Such comparisons are valid and meaningful. Because of differences in bookkeeping, comparisons between states as to the actual dollars spent per day have little meaning. To say that the percentage of the budget of New York State spent for mental health is larger than the percentage of the Mississippi state budget that goes for mental health tells you little about the comparative merits of the program. How-

ever, if Mississippi shows a small increase in the annual per capita expenditure for community programs between the two years, and a decrease in the percentage of all expenditures to the hospitals, while New York State shows a large increase in the per capita expenditure for community programs, and also an increase in expenditure for the hospital program, the comparison of the trends of expenditure in the two states has meaning when viewed in terms of the case load and labor conditions.

Correctly used, the statistics will be most helpful to citizen and administrator. The information is presented in an attractive form that facilitates a review of trends in any state in the nation. The graphic charts starting on page 36 are, in the opinion of this reviewer, the most valuable part of the study. The staff of the Joint Information Service is to be congratulated on this excellent compilation.

Jack R. Ewalt, M.D.

COMMUNITY MENTAL HEALTH—By Margaret C. L. Gildea, M.D., Charles C Thomas, Springfield, Ill., 1959, 169 pages, $5.

Since World War II the Western World has witnessed the emergence of vigorous programs of inquiry into sociocultural aspects of the prevention and treatment of mental illnesses. Psychiatry, it has been said, has emerged from the hospital and clinical office to join forces with the social scientist, the public health specialist, and community leaders. The resulting multidisciplinary efforts, sometimes marked more by enthusiasm than by rigor, have not usually lacked in imaginativeness and courage. Dr. Gildea and her associates in the St. Louis area during the past twelve years have shown both imagination and daring, in this reviewer's opinion, in at least three major areas: first, the utilization of trained lay leaders for mental health education with parent groups; second, the development of a simple scheme for the emotional classification of children by teachers and others; third, the creation of ingenious methods for the evaluation of community mental health programs. Much of this work has been published in professional journals. The stated purpose of this monograph is to bring together an exposition of the guiding concepts which led to the development of two major working programs, with full descriptions of the working programs themselves. For this it relies primarily upon somewhat expanded versions of previously published material.

Despite the promise implied in the title, the monograph is neither a comprehensive review of current approaches to and research in community mental health, nor an integrated description and evaluation of the St. Louis County project. Three separate content areas are brought into physical propinquity in three separate chapters; no integration is provided either in separate chapters or via interstitial material.

Chapter one begins with the briefest possible and entirely pragmatic rationale for the working programs that were developed. This rationale seems almost entirely unconcerned with the attempts of other workers in this complex field to

provide some theoretical underpinnings for community mental health research and service programs. The remainder of the chapter is devoted to a 1-2-3-4 classification system for children's emotional problems, based on behavior which is observable in the home or at school. Four levels of problem severity are proposed, ranging from transient disturbances—related to apparent environmental stress and creating little or no concern on the part of parents, teachers, and others—to the most severe and continuous difficulties characterized by an almost totally unfavorable balance between child and home. A sense of great simplicity is implied by the use of numbers to denote the categories of disturbance. While it may represent an over-simplification of complex issues, this approach does have the distinct advantage of providing a clear, operational, and behavior-bound category system for use by teachers in their everyday observations of children. The author fails, however, to make explicit the absolutely essential distinction between this form of *screening* process and the careful process of *diagnosis* that should form the ultimate basis for any remedial action. The author is also in the position of recommending application of a classification system for which no validation is provided.

Chapter two constitutes a separate report on group therapy with parents of moderately disturbed (group 2) children recruited through school personnel. Successes and failures in the program are carefully presented and there are some revealing summaries of the interplay of discussion in the groups. Chapter three describes the county-wide parent education program which used carefully selected mental health films and other audio-visual aids with leadership by trained lay people. The author suggests that such programs are most useful to parents of minimally disturbed (group 1) and normal children. These two reports are interesting and valuable in and of themselves. However, the major premise—i.e., that the category system leads to the most suitable assignment of children's problems to the parent group therapy or parent education approaches—is in no way validated by the findings presented. In fact, the most disappointing aspect of this monograph is that it omits the newer evaluative approaches developed by members of the St. Louis County team. Also missing are a concluding chapter or two in which the author could draw upon her many years of experience for an integrated evaluation of past work and for suggestions regarding possible future lines of development.

Dr. Gildea has much to offer in the way of experience. She has been working in the mental hygiene field with children for many years, first in clinics in Connecticut, then in the St. Louis area. She has been consultant to the St. Louis County Health Department and to the citizens' mental health association of St. Louis. She is also a member of the faculty of the Department of Psychiatry, Washington University School of Medicine. The richness of her background becomes apparent in the several subtle observations of clinical and community dynamics which are tucked here and there through the book, many of which are almost buried by the descriptive material. An example of such practical wisdom is the following: "Program chairmen or teachers only too often try to use a mental health program to bring recalcitrant parents into line. Nothing will more surely scuttle a program."

This review should not conclude without mention of two interesting Appendices, one an annotated list of mental health films, most of which are evaluated for use with different groups; the other a Discussion Leader's Manual used in the training of lay leaders. Both should serve as useful resources for those engaged in community mental health education.

Donald C. Klein, Ph.D.

AN INTRODUCTION TO CHILD PSYCHIATRY—By Stella Chess, M.D., Grune and Stratton, New York and London, 1959, 254 pages.

As is indicated in the foreword written by Lawrence B. Slowbody, M.D., professor of psychiatry, New York Medical College, and in the author's preface, this book is aimed at filling a fundamental need of newcomers into all the professional disciplines which are concerned with children and their parents—general practitioners, pediatricians, psychiatrists, student nurses, psychologists, speech therapists, and educators—for an introduction to the subject and procedures of child psychiatry. Like any author who volunteers to write an introduction to a very broad and complex subject for a quite heterogeneous reading audience, Doctor Chess has encountered three difficulties: (1) The question of just how much information in any particular area of the subject matter does it take to bring about an introduction; (2) The question of how the author can bring about an adequate introduction by placing the greatest emphasis on what seems to be the most important part of the subject being introduced; (3) The problem of how to keep the author's per-

sonal viewpoint from preventing a clear introduction. Each of these three areas is discussed below.

1. Doctor Chess has the conviction that it is possible and desirable to present material without the use of technical psychiatric terminology and complex and abstract formulations. This she achieves fairly well, in spite of the fact that in some areas the simplification seems overdone, and in others it is belabored. Still other areas stand out because of a higher degree of complexity and sophistication of presentation, comparatively speaking. The book is divided into twenty-one chapters which are grouped into five parts: Practitioner and Patient, The Child and His Parents, The Diagnostic Process, Diagnosis, and Treatment.

2. The first chapter contains an excellent historical review of the development of child psychiatry as a subspecialty, and as an indispensable part of general psychiatry, neurology, and pediatrics. The last chapter (8 pages) contains some general remarks about outpatient and inpatient treatment. In the nineteen chapters between, the child psychiatrist is the central figure, and a major portion of the material has to do with the interaction between the child psychiatrist and the child, and the meditations of the child psychiatrist on the production of that interaction. I do not mean to detract from the importance of the subject matter of the included chapters. I do submit that they are not inclusive enough to make for an adequate introduction (for the specified reading audience) to child psychiatry in the broad sense. Meaningful (to them) participation of the parents in the process of the diagnosis and treatment of their child (in any kind of treatment) is almost completely ignored. Psychiatric social work as a contributor to child psychiatry is almost completely ignored. Child psychology is ignored except as it can contribute additional laboratory data. The whole area of the role, contribution, and responsibility of child psychiatry outside the one-to-one doctor-patient interaction is left almost untouched.

3. (a) The justification for a subspecialty in child psychiatry, and the differences between child psychiatry and adult psychiatry are not spelled out clearly enough.

(b) "The Diagnostic Process," as presented in Part Three of the book, seems to be much more of an imposed, rigid, and mechanical procedure than a flexible, mutually-participated-in process out of which could come clear findings which the parents could understand and accept, and recommendations which they could participate in carrying out successfully. The first chapter of Part Three is "Taking the History." That seems an apt title since the entire chapter is concerned with extracting a history in 45 to 50 minutes. The only real giving that I could find in the chapter was conviction that the history be taken behind a closed door. The next chapter, "The Diagnostic Interview" (with the child), is much warmer and more giving. What happens after the contact with the child is unclear except that ". . . the psychiatrist has a responsibility to formulate a basic diagnosis with as much dispatch as possible, so that a treatment program can be promptly planned and instituted to put the child and his parents on the road toward the amelioration of any pathologic condition or environmental situation which may be uncovered." (Page 73)

(c) Psychiatric social work is not mentioned in connection with the diagnostic process.

(d) In the chapter "Special Diagnostic Procedures," it is stated that the psychologist who administers any testing as a special diagnostic procedure should be briefed in advance on the precise purpose for which the test is being given, and that he should have some knowledge of the nature of the youngster's difficulty or of any suspected pathology (Page 77). To me, such a statement means that the psychologist provides laboratory data on the basis of what he is told to do and without knowing all of the available information.

(e) Part Four of the book is Diagnosis. After presenting the problem of standardization of diagnostic nomenclature, the author proceeds to present her own classification of nine diagnostic categories. Ordinarily, I would not see this as an acceptable procedure in an introductory volume but in this situation it lends itself to a series of introductory statements about the nine categories: (1) Normal; (2) Organic brain disturbance; (3) Reactive behavior disorders; (4) Neurotic behavior disorders; (5) Neurotic character disorders; (6) Neurosis; (7) Childhood psychosis and schizophrenic adjustments; (8) Psychopathic personality; (9) Mental retardation.

(f) Part Five of the book is Treatment. In the chapter "Psychotherapy," there is a section on counseling of parents (Page 193). In this section, except for psychotherapy, any work with parents of a child in psychotherapy is considered in terms of guidance, advice, counseling, and suggestions. There is no recognition of an ongoing casework process with parents, concurrent with psychotherapy.

(g) The chapter on "Child Analysis" begins with an excellent brief resumé of the history of child psychoanalysis.

This is followed by a summary of the treatment of a nine-and-a-half-year-old child on a once-a-week basis over a period of a year and a half.

Robert E. Switzer, M.D.

FILM REVIEWS

The films reviewed this month fall into the category of "lecture films" and will probably find their greatest usefulness in teaching situations. Although films of this type usually contain much excellent informational material, they are often overlooked by motion picture users who may be put off by their didactic approach. When regarded strictly as "canned lectures," however, these films definitely deserve investigation. In a mental hospital, their chief value would be to supplement "live" lectures by instructors in training courses for nurses and aides.

UNDERSTANDING HUMAN BEHAVIOR (A series of 13 half-hour films produced by the Department of Psychiatry, College of Medical Sciences, University of Minnesota, in cooperation with the University's Department of Radio and Television Broadcasting.)

This series was originally prepared for showing on an educational television station and has recently been released in the form of 16 mm. prints. In the two lectures seen by this reviewer, Dr. Bernard C. Glueck, associate professor of psychiatry at the University of Minnesota, discussed MIND, UNCONSCIOUS MIND, AND THE BRAIN and THE CAUSE AND SIGNIFICANCE OF DREAMS. The general theoretical framework for these lectures is Dr. Sandor Rado's theory of adaptational psychodynamics. Reference is made to specific texts during the course of the lectures so that students may do further exploration of the subject. Dr. Glueck's presentation of this material is lucid and well-organized. For rental rates, please write to Audio-Visual Extension Service, University of Minnesota, Minneapolis 14. For purchase prices, please write to Audio-Visual Education, Wesbrook Hall, University of Minnesota.

A PHARMACOLOGIC APPROACH TO THE STUDY OF THE MIND (40 minutes, black and white, sound, 16 mm. Produced by Sherman Dryer for the Medical Education Department, Lakeside Laboratories, Inc., Milwaukee 11, Wisconsin. Available upon request from Lakeside Laboratories.)

In January 1959, a three-day symposium was held in San Francisco under the sponsorship of the University of California School of Medicine and the Langley Porter Neuropsychiatric Institute. Highlights of this symposium were filmed, and they form the basis for this lecture film. Narrating the film, and summarizing many of the speeches, is Dr. Ralph W. Gerard, director of laboratories, Mental Health Research Institute, University of Michigan.

In the first part of the film, which reviews the use of hallucinogenic agents, Dr. Leo Abood, Department of Psychiatry, University of Illinois College of Medicine, reports on the induction of "model psychoses" in volunteer subjects. In the second portion, devoted to the chemistry and clinical evaluation of certain monoamine oxidase inhibitors, a number of speakers present their findings. These include: Dr. Henry V. Agin, director of the Department of Neuropsychiatry, Beth-El Hospital, Brooklyn, New York; Dr. Nicholas A. Bercel, associate professor of physiology, University of Southern California; Dr. Sidney Cohen, VA Neuropsychiatric Hospital, Los Angeles; Dr. John Kinross-Wright, Baylor University College of Medicine, Waco, Texas; Dr. Nathan S. Kline, Rockland State Hospital, Orangeburg, N. Y.; and Dr. M. A. Pomeranze, New York Medical College. In a comprehensive review of these agents, Dr. Kline describes their effectiveness in treating depression.

Symposium Participants Discuss Pharmacologic Approach

Although charts and graphs are used to illustrate major points, the film has a somewhat static quality which is inevitable in a filmed record of this type. Nevertheless, it serves to bring the viewer on the scene of an interesting and important medical symposium. The film will be of greatest use to medical staffs of mental hospitals and to students of biochemistry, physiology, pharmacology, psychiatry, and psychology.

Jack Neher
Mental Health Materials Center

NEWS & NOTES

Administrative Psychiatry

A degree course (M.Sc.) in Administrative Psychiatry is offered by the Division of Community Psychiatry at Columbia University as one of its training programs under the joint auspices of the Department of Psychiatry and the School of Public Health and Administrative Medicine. The course supplements previous psychiatric training in preparation for administrative posts in hospitals, psychiatric clinics, and community mental health projects.

Over a 20-month period, candidates undertake 8 months of academic work at the university and a one-year on-the-job project, approved by the faculty and written up as a thesis. The project requirement can be fulfilled while regularly employed. The project year may follow or divide the 8 months at Columbia.

Students are usually carried on salary by their respective institutions during their 8 months on campus. Supplemental grants are available through N.I.M.H. to cover costs while at the university.

Inquiries may be addressed to: Dr. Viola W. Bernard, Director, Division of Community Psychiatry, School of Public Health and Administrative Medicine, Columbia University, 600 West 168th Street, New York 32, N. Y.

PEOPLE & PLACES

NEW YORK: **Mr. Samuel Davis** has been named assistant administrator of the Society of the Hillside Hospital in Glen Oaks.

Dr. Barbara Fish was appointed associate professor of clinical psychiatry at the N. Y. University College of Medicine and psychiatrist-in-charge of the children's service at Bellevue Hospital Center. Prior to this appointment, Dr. Fish was assistant professor of clinical pediatrics, instructor of psychiatry at Cornell University Medical College, and child psychiatrist at the N. Y. Hospital.

Miss Ruth Sensbach, former assistant to the N.A.M.H. director of field services, recently became assistant to its executive director.

Dr. Seymour Perlin is now chief of the newly-established Division of Psychiatry at Montefiore Hospital, New York.

QUARTERLY HOSPITAL PROFESSIONAL CALENDAR

AMERICAN PSYCHIATRIC ASSOCIATION

Annual Meetings:

1960 May 9-13, Convention Hall, Atlantic City, N.J. (116th)
1961 May 8-12, Hotel Morrison, Chicago, Ill. (117th)
1962 May 7-11, Royal York Hotel, Toronto, Can. (118th)
1963 May 13-17, Ambassador Hotel, Los Angeles, Cal. (119th)

Mental Hospital Institutes:

1960 Oct. 17-20, Hotel Utah, Salt Lake City (12th)
1961 Oct. 16-19, (Correction), Hotel Sheraton-Fontenelle, Omaha, Neb. (13th)
1962 Sept. 24-27, Hotel Americana, Miami Beach, Fla. (14th)

Other:

REGIONAL RESEARCH CONFERENCE, Mar. 18-19, Iowa City, Iowa. (Inq. W. D. Coder, M.D., Coordinator of Conferences, State Univ. of Iowa, Iowa City.)

OTHER PROFESSIONAL ORGANIZATIONS

NATIONAL HEALTH COUNCIL—National Health Forum, Mar. 14-17, Carillon Hotel, Miami Beach, Fla.

AMERICAN ACADEMY OF GENERAL PRACTICE, Annual Meeting, Mar. 19-24, Philadelphia, Pa.

NATIONAL COUNCIL ON ALCOHOLISM, Annual Meeting, Mar. 22-25, Statler-Hilton Hotel, New York City.

AMERICAN PSYCHOSOMATIC SOCIETY, Annual Meeting, Mar. 25-27, Sheraton-Mt. Royal Hotel, Montreal, Can.

WHITE HOUSE CONFERENCE ON CHILDREN, Mar. 27-Apr. 2, Washington, D. C.

GROUP FOR THE ADVANCEMENT OF PSYCHIATRY, Apr. 7-10 (Inq. Malcolm J. Farrell, M.D., Box C, Waverly 78, Mass.)

INSTITUTE ON MENTAL HEALTH ASPECTS OF PASTORAL COUNSELING, Apr. 25-27, Holy Family Monastery, W. Hartford, Conn.

MENTAL HEALTH WEEK, May 1-7.

AMERICAN NURSES' ASSOCIATION, Biennial Meeting, May 2-6, Exhibition Hall, Miami Beach, Fla.

AMERICAN PSYCHOANALYTIC ASSOCIATION, Annual Meeting, May 6-9, Chalfonte Haddon Hall, Atlantic City, N. J.

ACADEMY OF PSYCHOANALYSIS, Annual Meeting, May 7-8, Atlantic City, N. J.

AMERICAN ACADEMY OF CHILD PSYCHIATRY, Annual Meeting, May 8, Atlantic City, N. J.

ASSOCIATION OF MENTAL HOSPITAL CHAPLAINS, Annual Meeting, May 9-13, Atlantic City, N. J.

SOCIETY OF MEDICAL PSYCHOANALYSTS, Annual Meeting, May 11, N. Y. Academy of Sciences, 2 E. 103rd St., New York City.

AMERICAN ASSOCIATION ON MENTAL DEFICIENCY, Annual Meeting, May 17-21, Baltimore, Md.

AMERICAN GERIATRICS SOCIETY, Annual Meeting, June 9-10, Hotel Americana, Miami Beach, Fla.

SOCIETY OF BIOLOGICAL PSYCHIATRY, June 10-12, Hotel Deauville, Miami Beach, Fla.

AMERICAN ASSOCIATION FOR REHABILITATION THERAPY, Annual Meeting, June 13-17, Hotel Miramar, Santa Monica, Cal.

AMERICAN MEDICAL ASSOCIATION, Annual Meeting, June 13-17, Americana Hotel, Miami Beach, Fla.

CANADIAN PSYCHIATRIC ASSOCIATION, Annual Meeting, June 16-18, Banff, Alberta, Can.

even her fellow workers might not know—if her seizures are adequately controlled

Work is often possible when seizures are amenable to control by medication.[1] In one study,[2] the authors found about 75 percent of epileptics not only capable of work, but actually employed.

THE PARKE-DAVIS FAMILY OF ANTICONVULSANTS provides effective anticonvulsants for most clinical needs

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References: (1) Crawley, J. W.: M. Clin. North America 42:317 (March) 1958. (2) Lennox, W. G., & Cobb, S., cited in Yahraes, H.: Epilepsy—The Ghost Is Out of the Closet, #98, rev. ed., New York, Public Affairs Committee, Inc., 1957.

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OKLAHOMA: **Dr. Harry G. Hightower,** superintendent of Central State Griffin Memorial Hospital since 1955, retired at the end of last year. **Dr. Stanley Kemler,** its clinical director, resigned to enter private psychiatric practice in Oklahoma City. **Dr. Robert Ashley** was selected to serve as acting clinical director.

HERE & THERE: **Dr. Earl K. Holt, Jr.,** superintendent of New Hampshire State Hospital, Concord, has resigned. **Dr. G. Donald Niswander,** the assistant superintendent, has taken over as acting superintendent, and **Dr. Harrison Baker** as acting assistant superintendent.

The Naval School of Aviation Medicine and the Naval Hospital at Pensacola, Fla., have merged to form the Naval Aviation Medical Center. **Capt. Philip B. Phillips, MC, USN,** heads the department of neuropsychiatry. Residents in aviation medicine will spend 3 to 6 months on the NP service.

Dr. T. G. Denton, former assistant chief of psychiatry at McGuire VA Hospital in Richmond, Va., has succeeded **Dr. J. Kenworthy Ogden** as superintendent of Central State Hospital, Petersburg, Va. Dr. Ogden left for Australia where he will enter private practice. **Mr. Carroll H. Beck, Jr.,** is the new director of administrative services at Central State Hospital. He replaced Mr. Andrew W. Saphiloff.

Mr. Donald G. Shropshire, business administrator, Eastern State Hospital, Lexington, Ky., returned to the institution a few months ago after having completed a year in the graduate program in hospital administration at the University of Chicago. Mr. Shropshire was named winner of the first Carl A. Erikson fellowship in hospital administration, an award which will be given annually by the university on the basis of outstanding potential for a career in hospital administration.

Dr. Titus H. Harris, chairman of the department of P. & N., University of Texas, Galveston, was recently honored by his former residents who founded the "Titus Harris Psychiatric Club."

The Rev. Henry H. Wiesbauer, Protestant chaplain at Westboro (Mass.) State Hospital, was named program chairman of the 1960 annual convention of the Association of Mental Hospital Chaplains, to be held in Atlantic City, N. J. just before the A.P.A. annual meeting in May.

Dr. Stuart Schultz, a member of the psychiatric division of the Manitoba (Can.,) Civil Service for the past 34 years, recently retired from his position as medical superintendent of Brandon (Man.) Mental Hospital.

On January 31, **Dr. Dale C. Cameron** left the Minnesota Department of Public Welfare, where he was director of the division of medical services, to join the Training Branch of the National Institute of Mental Health, Bethesda, Md. Later this year he will be detailed to St. Elizabeths Hospital, Washington, D. C., as assistant superintendent. **Dr. David J. Vail** has been named acting director to replace Dr. Cameron in Minnesota.

Mr. A. L. Maines, director of administration at Logansport (Ind.) State Hospital for the past four years, has been appointed administrator of the Witham Memorial Hospital at Lebanon, Ind.

Dr. Archibald F. Ward, chaplain at Eastern State Hospital, Williamsburg, Va. since 1951, is now director of adjunctive therapy at State Hospital South, Blackfoot, Idaho.

Dr. Abraham Gelperin is the new administrator and director of research and training of the Neurological Hospital in Kansas City, Mo. He thus relieves **Dr. G. Wilse Robinson, Jr.,** of his administrative duties. Dr. Robinson has been in poor health for some time; he will, however, continue to participate in clinical activities.

The **Miles Standish State School,** Taunton, Mass., has changed its name. It is now the **Paul A. Dever State School.**

HAVE YOU HEARD?

TRAINING & RESEARCH: A new training and research program to provide for effective collaboration between the social sciences and health fields has been established at **Duke University,** Durham, N. C. Dr. John C. McKinney, chairman of the department of sociology, and Dr. Ewald W. Busse, chairman of the department of psychiatry, who head the program, explain that it has been established in recognition of the need for social scientists in medicine.

The new program at Duke is concerned primarily with research that utilizes the combined knowledge and skills of specialists in the social sciences and in medical-health fields, Drs. Busse and McKinney said. Medical advances have lengthened the average life span, and sociologists must join forces with the health team to make the added years of life a time of happiness and usefulness to society. The other principal activities of the program are teaching at the undergraduate level, and training research investigators in medical sociology.

VA hospitals have begun a new study using psychic energizing drugs in conjunction with tranquilizer therapy on schizophrenia. The purpose of this 16-week project is to test the effect of several drugs along with chlorpromazine. Reducing symptoms while building up and maintaining alertness and controlled activity is the goal of the project in which 27 VA hospitals and 500 patients are participating.

COMMUNITY ACTIVITY: The November 13 issue of *The Progress,* a tabloid published at **Patton (Cal.) State Hospital,** lists a number of businesses in the Los Angeles metropolitan area which have expressed interest in hiring former mental patients, provided they have the necessary job qualifications.

Treatment of mental patients through companionship of college students is one of the new therapies at the **Topeka (Kan.) VA Hospital.** Ten Washburn University students are spending about two hours a week each at the hospital. All facilities may be used by the youthful volunteers and the selected patients assigned to them. They play cards together, bowl, swim, ride bicycles, work in the hospital shops, and so on.

ADDICTIONS: In New York, the **Governor's Special Task Force** is recommending an amendment to the state's Mental Hygiene Law. The amendment would allow court certification of narcotic addicts to state institutions having special facilities for the care and treatment of such patients. This interim recommendation would provide an involuntary admission procedure for drug addicts. At present, facilities are limited to a 55-bed research unit established last fall at Manhattan State Hospital, Ward's Island, New York City.

A $1 million research grant has been awarded by the U.S. Public Health Service for a coordinated study of alcoholism in this country and Canada. The money will be used by the **North American Association on Alcoholism Programs** to establish a new and independent Cooperative Commission on the Study of Alcoholism. The commission will study the types of programs and trained personnel needed. Dr. Harold E. Himwich of Galesburg (Ill.) State Research Hospital has been appointed to a 16-member committee to select the commission and plan its first meeting.

CONSTRUCTION: With the approval of a site by the Ontario (Cal.) Planning Commission, construction in that city of a **100-bed hospital for the treatment of alcoholics** is virtually assured. At a cost of a quarter of a million dollars, the hospital will be built on a 10-acre site. Financed by private individuals, the institution will be the only one of its kind within a radius of 200 miles. It will not only be a "drying-out station," but will also provide the latest methods of treatment.

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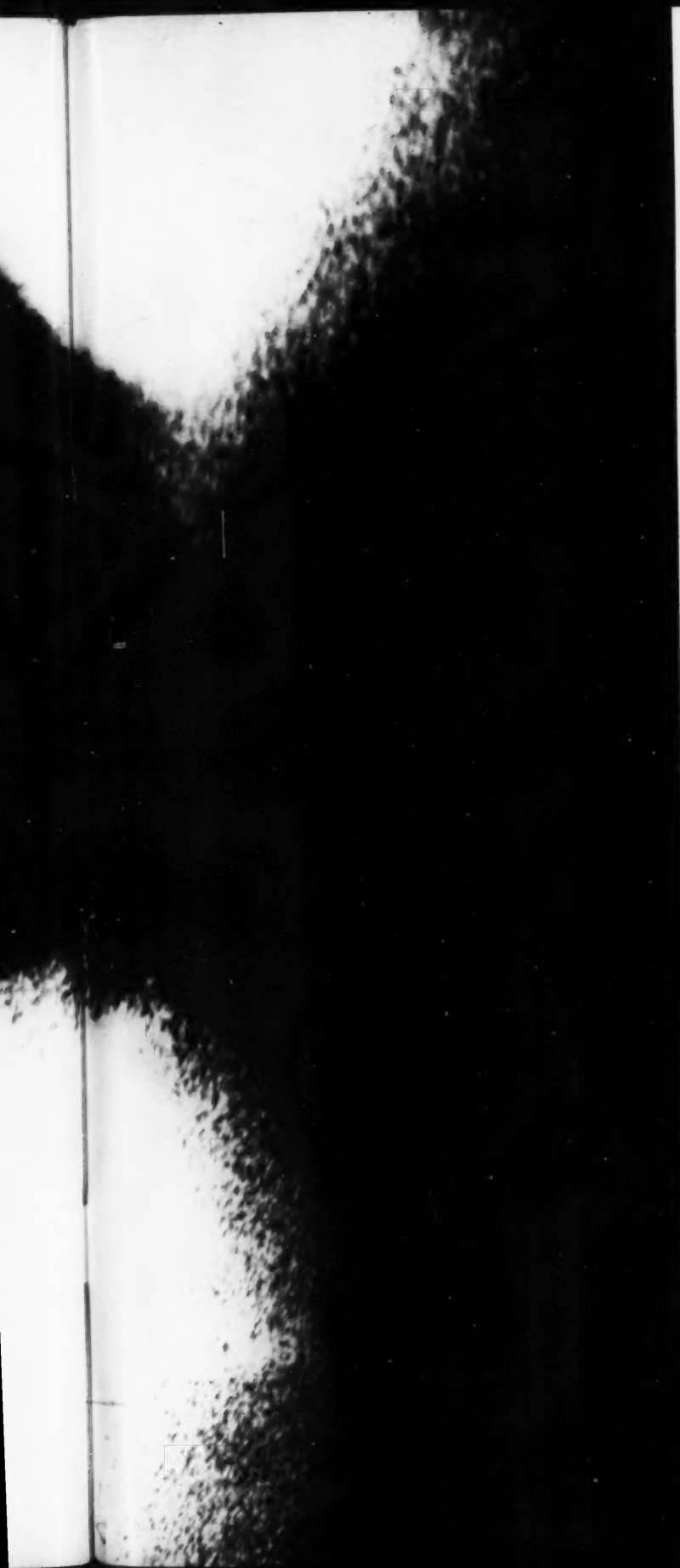

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1. Allen, V.S.: Trifluoperazine in the Treatment of Drug-Resistant Schizophrenics, J. Clin. & Exper. Psychopath. *20*:247 (July-Sept.) 1959.

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